The concept of the therapeutic community in British institutional psychiatry.

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THE CONCEPT OF THE THERAPEUTIC COMMUNITY

IN BRITISH INSTITUTIONAL PSYCHIATRY

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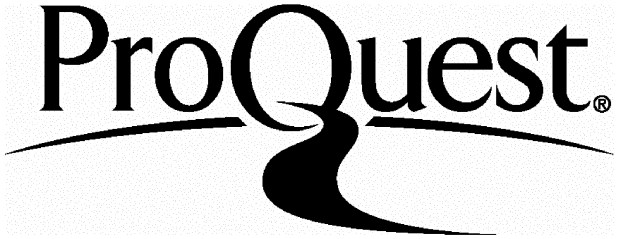

CONTENTS

LIST OF FIGURES

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SUMMARY

This sociological study examines the origins, development and uses of the concept of 'therapeutic community' in institutional psychiatry. It is divided into four parts, the first two containing a survey of all the available literature referring to the use of 'milieu therapy' and'therapeutic community'strategies in the treatment of (functional) mental disorders, and the last two containing a description of the author's fieldwork, followed by a detailed analysis of the operational usage of the concept of 'therapeutic community' in selected British psychiatric institutions.

Part 1 examines - and rejects - the claim for a distinctive sociological sub-discipline referred to as a 'sociology of psychiatry' and argues that 'dualism' in the theory and methodology of the social and medical sciences has served to confuse as well as delay the development of interdisciplinary cooperation between social scientists and the medical profession.

In Part 2 the origins of the concept of the 'therapeutic community' are traced through a review of social medicine since 1790. Special emphasis is placed - in chapters 5 and 6 - upon 'milieu therapy' as a reaction to 'custodialism' in institutional psychiatry after 1939. Chapter 6 provides a general overview of the developing concept of 'therapeutic community' and argues that much of what has been taken for granted about types of social structure, treatment goals and modes of therapy, requires a more discerning evaluation. In its present form, the concept is both confused and misleading.

Part 3 contains the results of the author's field research which was carried out in two stages over the period 1971-2. Stage 1 (Chapters 7 and 8) is concerned with establishing criteria of definition of 'therapeutic community' methods and shows that the staff of six selected psychiatric settings have a stereotyped image of the therapeutic community. The data suggest that the 'ideal type' community would consist of a relatively small unit (23 patients) that is located outside or away from the larger organisation to which it belongs, having semi-autonomous administration and the right to determine its own therapeutic policy. It would cater mainly for patients diagnosed as suffering from 'psychoneurotic' and 'personality disorders' although a 'therapeutic community' approach could be adapted to suit the needs of patients suffering from a wider range of disorders.
Stage 2 describes a participant-observational study of a developing therapeutic community and evaluates difficulties encountered in growth and transition. Various techniques were developed for gauging changes in ward atmosphere and morale and these are explained in chapters 9-13 along with an account of the problems encountered by the author in attempting to compromise two different approaches - the search for an acceptable (i.e. empirically justifiable) research strategy and the need for full time personal involvement in the daily life of the ward.
Part 4, contains summarial comments and general conclusions. It is the author's contention that the concept of the therapeutic community is seen to be progressive because it is <u>ideologically</u> opposed to traditional psychiatry. Due to its strong emotive overtones it takes on more the character of a 'symbol of progress' rather than a blueprint for organisation. For this reason users of the term are advised to distinguish carefully between what is essentially a theoretical construct and specific applications of the concept to practical settings.

PART 1

IN SEARCH OF A SOCIOLOGY OF PSYCHIATRY

CHAPTER 1

DUALISM IN SOCIOLOGY

The task of establishing and maintaining a sound position in the contemporary social sciences can be likened to the problem of determining the safest route across an area of swampland. On all sides one is surrounded by a surface which looks solid enough on first impression, but when probed deeper, often proves to be deceptively unsound. It soon becomes clear that finding a safe footing is as much a matter of faith in one's intuitive judgement as basing every step upon reasoned calculation.

Quite apart from the various levels of conceptual confusion, the discipline of sociology abounds with multivarious sources of enquiry; Functionalism, Ethnomethodology, Social Exchange Theory, Symbolic Interactionism - to name but a few. In the search for 'scientific' respectability it is to be expected that a discipline will have to tolerate the emergence of alternative theories and methodological strategies. For this reason, it is understood that 'social reality' means something essentially different to the functionalist and the phenomenologist. Differences of approach, do not, in themselves cause confusion within a discipline, however, the willingness to be aware of confusion or contradiction is a matter to which more than lip-service should be paid.

If, as Gouldner has suggested, the coming crisis of western sociology stems from a growing alienation of the personal experience of the sociologist from the phenomena that he studies, and if he is also

correct in his assertion that this widening gap is actually "a function of high science methodologies,"[1] then it would seem that the task of finding firm ground in sociology is as much a matter of personal awareness as it is reason.

A review of general sociological literature makes it abundantly clear that there are as many, if not more, 'subspecialities' of sociology, as there are theories or 'sources'. Practically every major, intellectually encompassable area of social life is covered by a 'Sociology of.....' something or other. Whether it is a Sociology of Education, of Industry, of Deviance, or of Psychiatry, one concludes that in its rise to academic pre-eminence, the general discipline of Sociology has found it necessary to encourage specialisation in fields that have become increasingly available to sociological interpretation though the widening application of the term 'social' to the relationship between man and his experiential world.

It is significant that Gouldner's proposed resolution to the crisis of western sociology lies in the creation of what appears to be yet another major subspeciality. 'Reflexive sociology', or a 'sociology of sociology', requests that the sociologist looks both at himself and at his discipline introspectively. Failure to do so ultimately means estrangement of the sociologist as a 'person' from the meanings he perceives in the subjects that he studies. This 'denial of self' is described as the "treacherous self" of conventional positivism.[2]

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1 Gouldner A.W. The Coming Crisis of Western Sociology. Heineman, 1970. P.56

2 Ibid P.495

A 'sociology of sociology' is, therefore, a search for authenticity in which the discipline is viewed not as "a bundle of technical skills", but as "a conception of how to live and a total praxis".[1]

One essential characteristic of Gouldner's thesis is that he talks of 'Reflexive Sociology' as being one out of many possible sociologies. In other words he sees sociology not as a discipline based ultimately on a consensual view of theory and methodology but as a series of possible alternative views. This idea is neither new nor particularly unique given that the emergence of the many sociological subspecialities reflects a series of comparative and alternative explanations of the fabric of society. However, Gouldner's approach is different in at least one respect. 'Reflexive Sociology' is not merely another subspeciality within the general discipline for it advances (whether Gouldner explicitly states it or not) a radical alternative to conventional positivistic sociology by its claim to be a moral sociology.[2] As an explanation of, and reaction to, the concept of value-freedom in positivistic sociology, Reflexive Sociology, not altogether unintentionally, establishes itself as a policy of opposition.

The reader will perhaps understand as we proceed further with this argument, the extent to which Gouldner's thesis reflects the malaise in which contemporary sociology finds itself. It is hoped that through further elucidation of some of the theoretical problems inherent in the attempt to establish a model of sociology in which the sociologist plays more than merely an external observer's role, that we may derive insight into the problems of establishing a 'sociology of psychiatry'.

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1 Ibid. p.504

2 Ibid. P.491

'The Crisis of Western Sociology' reflects Gouldner's longstanding concern with the questions of value-freedom in sociology[1] and the contemporary demise of Functionalism. In a nutshell, the thesis of his book runs as follows.

Western sociology is undergoing a process of convergence into a state of crisis, in which the dominant theoretical influence - Parsonian functionalism - is merging with its traditional target of opposition, Marxism. The ascription of conservatism inherent in the functionalist principle of social order; the criticisms that Functionalism ignores the problems of causation and disruptive social change, and the dependence upon large Welfare State - financed contributions for research, has resulted in an alienation of young sociologists from functionalism and the emergence of a growing number of societally-valid theories of opposition to functionalism. Furthermore, the rise of alternative theories embodying the notions of individualism and intersubjectivity, as well as the development of middle-range social problems research oriented to values of 'freedom' and 'equality' rather than 'order', has undermined the distinctiveness of funtionalism as a special school within sociology.[2]

It is extremely interesting on examination of these ideas, to find that one can still ask why the 'entropy' of functionalism heralds a crisis for Western sociology. The answer to this question lies not in Gouldner's expressed thesis, but in his supporting ideas.

The character of the terms 'domain assumptions', 'methodological dualism', 'moral sociology' and the 'treacherous self of conventional

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1 Gouldner A.W. Anti-Minotaur: The Myth of a Value Free Sociology.

2 Gouldner A.W. 1970 Opcit P.410

positivism', express Gouldner's dissatisfaction with the notions of 'objectivity' and 'value freedom' in sociological theory. He appears to doubt the credibility of positivistic methodology in the social sciences. If this assumption is correct, it strikes one as odd why he considers the question to be of secondary importance to the wider issue of the 'entropy' of functionalism. To doubt the validity of the positivistic method and to present a 'moral sociology' as a radical alternative, is, surely, a major thesis in itself?

It is not clear from his use of the phrase 'domain assumption', which describe the "tacit assumptions that theorists make about the domains with which they concern themselves",[1] to what he is referring.

He seems to imply that domain assumptions contain ideological components that distinguish modes of theoretical analysis. For example, he states that:-

"It is an almost overpowering temptation particularly for those sociologists who need to think of themselves as scientists, to present their domain assumptions as if they were empirically substantiated 'facts'."[2]

In other words, if the sociologist's domain assumptions are expressed in terms of phenomena modelled on the principles of the physical or natural sciences, then it follows that such subject matter "may be treated and controlled in much the same manner that other sciences control their non-human materials.."[2] Once having assumed this objectivist stance the methodology of sociological enquiry "seems a purely technical concern devoid of ideology; presumably it deals only with

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1 Op Cit p.34

2 Op Cit p.35

3 Op Cit p.50

methods of extracting reliable information from the world, collecting data, constructing question aires, sampling and analysing returns."[1]

It would be to underestimate Gouldner's analytical sophistication to imagine that his critique of, what he terms, 'Conventional Positivism' rests on such elementary principles as these. One has to look further at his supporting ideas in order to understand what it is about positivistic sociology that he finds inadequate.

It is in the concept of 'methodological dualism'[2] that we find the essence of his critique of positivism. Methodological dualism refers to the "differences between the social scientist and those whom he observes".[3]

It describes the separation of subject and object through the sociologist's personal detachment from the world he studies. Gouldner explains this need for separation as the sociologist's fear of his 'own self' becoming 'contaminated' through over-involvement with the subjects of his studies. Presumably the 'uncontaminated' sociologist is able to deal with the 'real' or 'natural' world. Gouldner replies to this by arguing not that such a view is wrong, simply that it is methodologically naive, and morally mistaken.

"What Methodological Dualism ignores", he continues "is that the sociologist does not only enter into consequential relations with those whom he studies, but that these relations themselves operate within the orbit of the relations that the sociologist has with those who, directly or indirectly finance his researches and control his occupational life and the establishments within which he works.....

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1 Op Cit P.55

2 Op Cit P.495 (Gouldner's Italics)

Its claim to "objectivity" is, in effect, commonly made in such a way as to give least offence to those who most subvert it".[1]

The sociologist is, therefore, naive in assuming that his personal non-involvement can be honestly and realistically maintained. Conformity to the requirements of those supplying research funds, leads to the kinds of compromise of values and research perspectives that ultimately result in a "dulling of the sociologist's awareness". Reflexive sociology on the other hand, rests upon an awareness of this fundamental paradox, "namely that those who supply the greatest resources for the institutional development of sociology are precisely those who most distort its quest for knowledge".[2] Thus, in order not to limit the significance of one's research, the sociologist is asked to admit freely to his own feelings about his involvement with the subjects of his study and to what extent the requirements of the bodies for whom he is working, have influenced his theoretical and methodological approaches.

It is obvious from such a line of argument that the principle of 'value freedom', so central to conventional positivistic sociology, is rejected in favour of a 'value-committed' approach. Gouldner admits to seeing the dangers of such an approach, but argues that a Reflexive Sociology is stronger for being aware of them "for it prefers the risk of ending in distortion to beginning in it, as does a dogmatic and arid value-free sociology".[3]

One of the main reasons for arguing that Gouldner's thesis rests primarily on the problem of defining the epistemological status of sociology, is because he endeavours to clarify the distinction between

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1 Op Cit P.497

2 Op Cit P.498 (Gouldner's Italics)

3 Op Cit P.499

knowledge as information and knowledge as awareness.[1] Those believing that the social sciences should model themselves upon the principles of the natural sciences have tended to view the acquisition of knowledge as a process of confirming their assertions about reality through the use of empirical techniques in the collection of information. "Science thus construed" claims Gouldner, aims "at producing information either for its own sake or to enhance power over the surrounding world; to know in order to control".[2] Implied in this statement is the alienation of the sociologist from his subject, or the view that experience is external to man.

Gouldner's suggestion that the early positivistic approach to the study of social phenomena modified under the influence of Weberian normative sociology, is significant in the sense that the acceptance and utilisation of, normative concepts has ultimately led to sociologists challenging the validity of 'value freedom' as a central sociological principle. As long as the theoretical stance of the sociologist forbade him from making value judgements about the things he was studying, he was protected by his 'scientific' status. When faced however, with the criticism that value freedom implied 'shirking one's moral responsibility' the positivist found himself being asked to defend the formal principles of his science and methodological strategy.

Instead of seeking to clarify the methodological problems inherent in value-free sociology, sociologists have too often avoided the question by claiming that their phenomena belong to 'permitted' or 'unpermitted' worlds, thus leading to a separation of the sociologist's awareness of his aims, motives and values from the information he

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1 Op Cit P.491

2 Op Cit P.491-2 (Italics Mine)

collects.

If Gouldner had ended his study simply by proposing 'Reflexive sociology' as an alternative approach to traditional empirical sociology, one might have been able to argue that his whole thesis was nothing more than another academic contribution to the continuing debate over the nature and scope of General Sociology. However, his final remarks point convincingly to his underlying conception of the real 'crisis' of western positivistic sociology.

In essence he is arguing that value-freedom as the principle component of methodological objectivity, is no longer possible, for "it becomes unblinkingly evident that sociology has become dangerously dependent upon the very world it has pledged to study objectively... This dependence is dissonant with the ideal of objectivity".[1]

In other words, if the sociologist cannot realistically claim to be value-free owing to expectations that are implicitly built into his research frame work then he should seek only to be as objective as possible whilst admitting to the influence of these other factors. It is with this principle in mind that Gouldner offers Reflexive Sociology as a possible means of limiting the crisis within the discipline.

"A Reflexive Sociology, or a Sociology of Sociology.... is based on a.... kind of experience.... that warns that it is not only forces external to the intellectual life but also those internal to its own social organisation and embedded in its own distinctive subculture that are leading it to betray its own commitments.... there is no way of making a new sociology without undertaking a new praxis".[2]

Reflexive Sociology, therefore, unlike other theoretical approaches is as much concerned with the role of the sociologist as with the nature

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1 Op Cit P.511 (Italics mine)

2 Op Cit P.512

of sociology. It seeks to establish a means by which the sociologist can allay his anxieties about not being 'scientific' whilst at the same time learning to respect the importance of self awareness and insight in the course of his research.

Gouldner has gone to considerable lengths to emphasise the point that sociologists should "cease acting as if they thought of subjects and objects, sociologists who study and laymen who are studied, as two distinct breeds of men".[1] This rejection of dualism reflects many of the influences of symbolic interactionism and phenomenology upon recent sociological theory.

Whereas, for example, Durkheim tended to view 'social facts as things', that is, "as existing outside and independent of cognition", which led to methodology being oriented towards "a search for objective indices of societal states rather than towards introspection or case study methods...",[2] W. I. Thomas and William James tended to argue that the objects of cognition cannot have a separate existence from the persons observing and interpreting them. It has been suggested that the

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1 Op Cit pp.490-491

2 Kienzle H.J. Epistemology and Sociology BJS, (21) 1970 P.421

emphasis laid upon the "subject's manipulation of his environment led Thomas to his famous 'definition of the situation' ", and that with the influence of pragmatism and of German social thought in sociology, attention was shifted "away from the objective to the subjective, by insisting on the importance of the phenomenology of the actors in the study of sociology".[1]

Terms such as 'dehumanisation' and 'reification' have become increasingly acceptable in sociological discourse. Mechanistic models of man and society have gradually fallen into disrepute as more dynamic conceptions of the social world have emerged. As the notion of voluntarism, which stresses the place of choice, decision, purpose and values in social action, modified positivistic sociology, turning it away from descriptive analyses of social behaviour to normative evaluation of meaningful social action, the epistemological assumptions of sociology began to be viewed as inadequate. The more that man began to be seen as having the ability to change his environment by choice, the more difficult it became for the sociologist to isolate phenomena for controlled study or to hold to any manageable theory of social statics. Thus the emergence of a more dynamic conception of the nature of the social world was called for.

What was more important than the changes taking place within sociological theory, was the need to preserve a methodology consistent with the prerequisites of a scientific status. So long as methods of collecting data could be seen to be methodical and rigorously objective, this at least ensured some degree of scientific validity.

One of the major problems in trying to maintain an objective

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1 Kienzle H.J. Epistemology and Sociology BJS, (21) 1970 P.421

methodological approach lies in the choice of method made by the researcher. It is evident that the commitment to a particular series of methods reflects the ideological predisposition of the sociologist. This would not matter particularly if all methodological strategies carried equal scientific status but this is not the case.

The contemporary sociologist faces real difficulty in trying to discover methods of enquiry that do not either limit the nature of his involvement with his subject matter to such an extent that it becomes 'lifeless', or enable him to become so involved that he is accused of bias.

Statistical testing of qualitative information can sometimes satisfy the necessary criteria of objectivity, providing that the techniques used in the collection of the data were themselves carefully chosen. If, however, it is really impossible to control the influence that the researcher is having upon his data, it may be better to state them clearly rather than delude oneself into believing that they will be dealt with by 'other controls' such as quantitative statistical analysis.

Gunner Myrdal suggested in 1944 that "There is no other device for excluding biases in social sciences than to face the valuations and to introduce them as explicitly stated, specific and sufficiently concretised value premises".[1] Schwartz and Schwartz claim that Myrdal was assuming that bias is a universal phenomenon and that it is important that the observer knows and can specify what his biases are in order to prevent distortion of his observations.

As one reviews the general direction in which, particularly American sociology is moving, it appears that Gouldner may be correct

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[1] Myrdal G. An American Dilemma. N.Y.. Harper & Bros. 1944, P.1043 (in M.S. & C.G. Schwartz. Problems in Participant Observation. A. J. Sociology, 60, Jan. 1955 pp.343-353).

in his assertion that the coming crisis is essentially a methodological one. He may, however, have overlooked one aspect of this methodological dilemma by focussing too heavily upon the problems inherent in functionalism.

Sociological theory, has come to accept to a far greater extent than ever before, subjective and relativistic notions of man, experience, and society. In much the same way that Freudian psychoanalysis upset the psychiatric applecart by claiming that conscious reason was less important than unconscious motivation in the origin and management of certain behaviours, symbolic interactionism and existential phenomenology have, through their consistent emphasis upon intersubjectivity and awareness, gradually reduced the applicability of objective methods to the study of social phenomena. This situation has arisen not because conventional empirical techniques are inadequate, rather than their scope of relevance has declined.

A positivistic theory of man or of society is easily complemented by an empirically-based methodology, because, what you study and how you study it, derive from the same epistemological foundations. In other words, if one holds to a biophysical model of man and one is interested only in knowing the extent to which the size of the brain is a causal factor in the incidence of mental disorder, the techniques adopted are empirical, because measurement, description and reporting of results are all basically fact-finding tasks concerned with substantiating an empirical theory of man. In such cases, opinions, interpretations and personal value-judgements present in the selection of hypotheses are not seen to influence the construction of the theory or the collection of the data. Even if these evaluative factors do have a relevance to the nature of the study they are generally ignored, often because certain

assumptions about man and the nature of experience are taken for granted.

Tacit assumptions are not defensible unless the professional body to which the researcher belongs, itself supports, or would not deny, the assumption in question. Sociological phenomena do not lend themselves easily to empirical verification and in general, unless the sociologist can base his theoretical suppositions upon principles that the professional community will readily accept, he stands the chance of having his work branded as 'unscientific', 'unprovable', 'unsubstantiated by fact', or even 'irrelevant'.

Despite these factors, it is still the case that the discipline of sociology has modified considerably during the past decade for there has developed from within it, a lessening concern with the need to be 'scientific' and a wider interest in providing insight into areas of social experience that the conventional sciences cannot provide.

It may be as a result of this changing orientation that many of sociology's subspecialities have been able to emerge, although it is likely that the major inconsistencies within general sociology stem from the widening gap between theory and methodology.

What appears to be happening is that the epistemological assumptions underlying theoretical models in sociology are becoming separated from their counterparts in the methodology of the social sciences. Whereas the change from behaviouristic models of man to voluntaristic models has been accompanied by changes in methodology such as from descriptive to normative empiricism, the change from voluntaristic to intersubjective models of man and action have not until recently been matched by similar methodological innovations.[1] Most methods of

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[1] See reference to 'Grounded Theory'; Part 3, Chapter 11

studying social interactions or the meanings that lie within them still tend to rely on positivistic or quasi-empirical techniques of investigation derived, if not from sociology, from social psychology, economics, and other such fields of enquiry.

The more 'subjective' that theory becomes and the more that it relies upon philosophical concepts to define the nature of man and his experiential universe, the more inappropriate empirical methodology appears to be in relation to theory. It may be that having established itself as a mature discipline, Sociology is now realising that it does not have to rely upon having the status of a science to be respectable. Kienzle maintains that:

"The starting point of sociology, like any science, is a philosophical affair. More important, philosophical ideas may still influence, however subtly or unintentionally, the Sociologist's attempt to study and understand his subject matter to think that philosophical positions only influenced the sociologists of the past, moreover, is to ignore their possible influences today. It is for this reason that philosophical analysis is just as important to the contemporary scientist as it is to the historian or theoretician. It can have a direct, positive effect on the quality of scientific sociology".

He furthermore asserts that:

"Philosophical awareness may help us to see that existing controversies over the nature, scope and subject matter of sociology are fundamentally philosophical controversies that cannot be settled on empirical grounds".[1]

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1 Kienzle H.J. Op Cit P.422

Winch[1] has argued, albeit on different grounds, that sociology is a branch of philosophy rather than empirical science. He holds that because all social phenomena are meaningful and all meaningful phenomena are rule-governed, by following the 'rules' we learn by direct experience, which leads one to the conclusion that the best method for social science is philosophical analysis, which is the 'task of learning rules'.

The phenomenological school within sociology has come to view the concept of intersubjectivity as the acquisition of knowledge through 'immediate awareness'. That is, the individual's subjective awareness of the meanings inherent in social interaction is a process by which knowledge of the experiential world is grasped.

The essential difference between objectivist and phenomenological ways of looking at social acts lies in the distinction between their definitions of method. The positivistic sociologist describes, explains and interprets the meaningful acts of social participants whereas the phenomenologist sees human subjectivity as an active, creative force in the constitution of the real world. "From the onset, we, the actors on the social scene experience the world we live in as a world both of nature and of culture, not as a private but an intersubjective one, that is, as a world common to all of us. The mistake of naturalist and empiricist sociology is that it takes this social reality for granted."[2]

The idea of 'awareness as process' is carefully analysed by Peter Berger in his explanation of the process of becoming aware of one's own

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1 Winch P. The Idea of a Social Science. Routledge & K.P. 1958.

2 Speier M. Phenomenology and Social Theory: Discovering Actors and Social Acts. Berkely J. of Sociology V12 pp.193-211, 1967.

subjectivity in terms of a dialectic. Society, he argues, is a dialectical phenomenon in the sense that it is the product of man and man of it, and can have no other being except that which is bestowed upon it by human activity and consciousness.[1] In the phenomenological critique of sociology, 'objectivity' is seen as leading not to the elucidation of social reality, but to an ignorance of consciousness. "The objectification of social phenomena has obscured the importance of human subjectivity..." writes Berger in an earlier paper.[2] Man seen only as an enactor of roles is an example of 're ification' in which the concept of role separates the actor acting, from the action; that is, actions are perceived as being separate from their performer. If the actor is perceived as the embodiment of roles, roles precede existence and hence roles, not people, become the prime reality. As institutions are only role structures, then people do not exist, and structure is reified.

In order to counteract these intrinsically dehumanizing processes, Berger and Pullberg have suggested that the task of sociology is to synthesise its mainstream ideas with those of philosophy and psychology. Their thesis is straight-forward; in the past, consciousness was the province of philosophy, whereas empirical analysis of the location of consciousness has been the province of psychology. Thus, "a sociology that retains its grasp of itself and its subject matter must be a continuing classification of everyday life. A critique of consciousness is the stuff of everyday life".[3]

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1 Berger P., Luckman T. The Social Construction of Reality.

2 Berger P., Pullberg 'Reification and the Sociological Critique of Consciousness'. History and Theory, Vol 4, Pt 2, 1965

3 Berger P. & Pullberg. Ibid P. ?

When one looks critically at these different ideas certain significant features emerge. The concept of relativism seems to underpin all theories of intersubjectivity in the sense that it implies that the individual is both a product and a producer of social structure and culture and hence the individual act has to be observed and understood not only within its particular setting but in terms of how the individual's consciousness of his situation structures the meaning of that setting for others.

The subjectivity of the phenomena of experience provides the sociologist with the problem that both Gouldner and Schwartz refer to; whether to admit to one's own influence in a particular setting and to use it constructively, or to try to limit one's involvement and hence one's influence on the subjects of study with the possible result that the researcher is unable to grasp some of the less available subjective material.

For the sociologist who regards the pursuit of sociological knowledge as a process of 'becoming aware in order to understand', limitation of involvement can mean loss of insight into one's subject matter. This is particularly the case in the study of psychiatric treatment procedures where the sociologist is asked to understand emotional transactions and subjective interpretations of actions which require a personal involvement of a kind that sociology has traditionally viewed as being liable to distort the sociologists perceptions of his subject matter.

If one works under such conditions it often appears that objective methods of data collection are insufficiently adaptable to the study of subjective phenomena. Sometimes, because these methods require careful planning and application, for example in the case of questionnaire or interview schedules, the situations in which they are used can prove

to be too transient for accurate information to be collected. This problem arises partly as a result of the requirement that methodology be 'objective' in the sense that the sociologist's main aim should be to establish 'facts' whether at source, or during the process of later calculations.

It should not be assumed that this procedure is mistaken in the sense of being logically untenable, but it is important to realise that the sociologist's awareness of his own feelings and of his influence on the situation in which he works, to a certain extent changes or gives particular weight to the 'facts'. This in no way limits the value of his participation but in strict empirical terms it may de-objectify his status as a 'scientist'. Whether this matters or not to the individual sociologist is determined to a large extent by the position he maintains with regard to the empirical purpose of sociology.

Apart from his personal considerations there is also the professional community to think of, for it is they that ultimately sanction the validity of his findings.

The dilemma that the contemporary sociologist faces then, reflects the changing nature of sociological enquiry. As the subject field of sociology widens, throwing up new subspecialities as it seeks to define the general nature of social reality, new theories, perspectives and methods are emerging, often in opposing directions.

Whereas sociology has traditionally striven to present its theories and methods in an objective manner in a quest for professional and scientific status, contemporary sociologists seem to be showing less concern with the question of the status of their discipline in society. What has happened to sociology is not as important any longer

as what sociology is contributing to other disciplines and walks of life.

The real problems of theory and method do have far-reaching implications for the discipline of sociology, yet as one reads Gouldner's thesis and takes account also of the claims that have been made for the philosophical or subjectivist nature of sociology, one cannot help feeling that these critical appraisals and theoretical diversions are not spelling out foreboding concerning the future of sociology, but are simply giving warnings about the possibilities of becoming too complacent or even, old fashioned.

When a request is made by an eminent sociologist for the discipline to which he is committed to become more introspective, one gets the feeling that something intrinsically healthy is taking place and that warnings of 'crisis' are most probably a manifestation of a need for critical reappraisal. It is significant to note that Gouldner refers only to a '<u>coming</u>' crisis; he does not actually state that it is upon us, which might explain why his 'reflexive sociology' appears to be a radical attempt to halt a general sociological decline.

It is with these ideas in mind that we turn now to an examination of some of the problems facing the sociologist in his attempts to establish the theoretical and practical statuses of a distinctive 'Sociology of Psychiatry'.

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CHAPTER 2

DUALISM IN PSYCHIATRY

It has been argued in the preceding chapter that sociology is undergoing a change of direction in which its theories and methodologies are becoming subject to greater critical scrutiny as a result of a growing challenge to its central principles of positivism and value freedom.

In a similar manner, psychiatry is undergoing a change of a type that in many respects resembles that of sociology. Not only has psychiatry's traditional dependence upon the medical profession and its models of pathology been subjected to wide-ranging criticism both from within and outside the discipline, but it has even been described as a non-science, or a form of moral philosophy.[1]

Remembering Gouldner's claim that reflexive sociology advances a radical alternative to conventional positivism through its emphasis upon the sociologist's awareness of his own 'moral investment' in his work, it is interesting to find that a similar parallel can be drawn in contemporary psychiatry.

Szasz has pointed out that definitions of mental illness "may be viewed as a manifestation of strain in an individualistic society."[2] He argues that mental illness, apart from being a 'myth', is an ambiguous label since "those who use it seem to wish to straddle and evade the conflict of interest between the patient and his social environment".[2]

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1 Szasz T.S. Law, Liberty and Psychiatry. NY MacMillan Co., 1963 P.15

2 Szasz T.S. The Myth of Mental Illness. Secker & Warburg 1962. Granada Pub. Co. Paladin 1972. P.85.

Whether by the words, 'those who use it', he is referring to medical practioners and other formal agents of care, is not clear, but Szasz does emphasise an evasion of moral responsibility that seems to pervade the psychiatric profession.

"This evasion of interpersonal and moral conflicts by means of the concept of mental illness is revealed by the current 'dynamic psychiatric' view of American life, according to which virtually every human problem - from personal unhappiness and marital discord to political conflict and deviant moral conviction is regarded as a symptom of mental illness".[1]

The kinds of questions that Szasz raises in American psychiatry can be compared to some of the questions that Gouldner has raised in sociology. For example, Gouldner's 'Reflexive Sociology' stresses the importance of the 'processual' nature of social phenomena and the means by which the sociologist becomes aware of his part in this process. Szasz has argued in his introduction to the 'Myth of Mental Illness' that:

"Sooner or later every scientific enterprise comes to a fork in the road. Scientists must then decide which of the two paths to follow. The dilemma that must be faced is - how shall we conceive of what we do? Should we think of it in terms of <u>substantives</u> and entities..... or ..... in terms of <u>processes</u> and <u>activities</u>. These two modes of conceptualisation represent a developmental sequence in the evolution of scientific thought. Entity-thinking has always preceded process-thinking. Physics, chemistry, and certain branches of biology have long ago supplemented substantive conceptualizations by process theories. Psychiatry has not".[2]

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1 Ibid P.86

2 Ibid P.17

The 'fork in the road' that Szasz refers to in his description of the separation of entity and processual thinking in the sciences resembles Gouldner's notion of 'methodological dualism' in which social phenomena are distinguished in terms of having 'information' or 'awareness' content, the former involving the perception of data as 'objective entities', and the latter as 'subjects of awareness'.

Another similarity between Gouldner's critique of sociology and Szasz's critique of psychiatry is the claim that both disciplines, which deal with animate, processual phenomena, have much to benefit from closer links with philosophy and ethics.

As we saw in the previous chapter, a number of sociologists have stressed the subjective and philosophical nature of sociological concepts and methodologies. In a similar vein, Szasz comments upon the relevance of philosophical ideas in psychiatry.

Referring to the relationship between psychiatry and ethics, he argues that psychiatry, as a theoretical science, is nominally concerned with the study of personal conduct. That is, it starts by attempting to clarify and explain 'the kinds of games people play with each other'.

Since verbal communication is most often the medium of expression of both the 'game-player' and of psychiatry, it is thus 'in the structure of language games that the interests of linguistics, philosophy, psychiatry and semiotic meet. Each of these disciplines has addressed itself to different aspects of the language game: linguistics to its structure, philosophy to its cognitive signification and psychiatry to its social usage"... It is hoped that... "this approach will effect a much needed and long-overdue rapprochement between psychiatry on the one hand and philosophy and ethics on the other".[1]

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[1] Ibid P.24

On the relationship between psychiatry and sociology, Szasz, like Gouldner, holds that the relationships between social phenomena and the contexts in which these can be understood and explained, are relativistic in nature.

"What, then, can we say about the relationship between psychosocial and physical laws? The two are not similar. Psychosocial antecedents do not 'cause' human sign-using behaviour in the same manner as physical antecedents 'cause' their effects. Furthermore, just as physical laws are relativistic with respect to man, so psychological laws are relativistic with respect to social conditions. In short, the laws of psychology cannot be formulated independently of the laws of sociology".[1]

Rogow[2] describes the separation of schools of thought as being indicative of a 'crisis' in American psychiatry. He asks whether the future direction of psychiatry and psychoanalysis is likely to branch out in the direction of social and community involvement, the subjective psychotherapies, or perhaps even biochemistry and neurophysiology. He points out that if it is difficult to know in what direction psychiatry seems to be developing it should not be assumed that it is a problem, particular to psychiatry alone. This problem is basically no different from ... "questions facing other professions, groups and classes who have reached a critical crossroads in history".[3]

The idea of 'separation' or 'dualism' plays an important role in the contemporary social sciences. These ideas derive from a longstanding problem of defining the epistemological nature of human experience. The

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1 Ibid pp.23-4 (Szasz's Italics)
2 Rogow A.A. The Psychiatrists D & H Pub. Co. N.Y., 1970.
3 Ibid P.30

predilection of Western philosophy with the attempt to separate 'subjects' from 'objects', 'mind' from 'Matter', 'noumena' from 'phenomena', 'God from man', 'free will' from 'determinism', 'form' from 'content' and so on, has resulted in a general acceptance of dichotemous forms of explanation in the examination of the phenomena of experience.

The search for 'objective truth' which has traditionally been viewed as the central purpose of the sciences, was itself born out of the need for systematic explanation of man, and the universe. As science strove to create a sense of order out of the 'facts' it purported to be discovering, it limited, by virtue of its own methods of proof and prediction, the opportunity to utilise personalised subjective modes of enquiry and explanation.

There is no doubt that man has always needed science to provide him with a greater understanding of his world and to better his conditions of life; however, the overriding emphasis placed upon the need for objectivity has to a large extent resulted in, not just the creation of dichotemous principles, but more significantly, in the ascription of a 'negative' status to one of them. To introduce, for example, a subjective theory into an 'objective' discipline implies that the theory must prove its positive value to that discipline before it is accepted. In other words, given that the traditional purpose of western science has been to establish, through fact-finding procedures, the positive nature of reality, those concepts, methods and aims consistent with this general purpose will be judged as legitimate, whereas those that are inconsistent or in doubt, will not.

A common misconception of many critics of scientific method, is that they speak of the study of natural phenomena as being synonymous with the sciences of inanimate matter, hence relegating the study of social or psychical phenomena to an area outside of the scientific realm.

Yet, to say that an observation described in terms other than those of the sciences cannot be scientific is to deny man's subjective capability of arriving at valid conclusions about his experiential world.

In a valuable discussion of the status of psychoanalysis within psychiatry, Main[1] explains the fallaciousness of assuming one correct method of arriving at knowledge. He holds that the "a priori readiness to select and admit for study only certain phenomena, and to rule others out of court, to insist that the method of material science must be the method for all science, together with the belittling of other methods of arriving at knowledge, is itself, of course, unscientific. Not only does it dictate to the facts rather than attempt to respect and understand them, not only does it require all facts to suit one method rather than seek to devise methods to suit facts, but by its insistence on only one method it turns its back on the major matters of human experiences, simply because these cannot be ordered according to the principles of inanimate matter".[2]

Main admits that the choice to be taken is either to accept that the experiencing of human life is not a matter for science, but instead for humanists and philosophers, or alternatively to seek to enlarge the definition of science by legitimising and tolerating other methods than those of material science. Whichever course one chooses, he

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1 Main T.F. Psychoanalysis as a Cross-Bearing. Brit. J. Psychiatry. 1968, 114, pp.501-7.

2 Ibid p.502

argues, the psychiatrist cannot avoid knowing that "Psychical experience remains there, neither material nor objective, but indisputably psychical and subjective".[1] To avoid being aware of this, the psychiatrist, says Main, has to accomplish a major feat of blindness. The chemistry and physics of the human body may be explicable in materialist terms but psychical experience - or human subjectivity - "can never be described except in psychological terms".[1]

It is clear that Main interprets the subject matter of psychoanalysis as being unavailable to 'conventional' scientific validation. The psychoanalyst does not seek to prove the validity of his client's experience, he views instead the psychoanalytic experience as playing an essential role in the patient's development of insight and awareness. The practice of psychoanalysis is markedly different from the practices of medical psychiatry, for the latter's origins are firmly grounded in the science of medicine. It is, therefore, of considerable importance to be aware of the distinction between those psychiatric theories and methods that utilise medical models of mental disorder and those that do not.

In the earlier discussion of types of 'knowledge' in sociology it was shown how Gouldner distinguished between knowledge as 'information' and knowledge as 'awareness'. It was further implied that this dichotemy characterised two separate modes of sociological involvement, the former to a value-neutral or 'external' approach which emphasises the importance of observation and description of phenomena, and the latter to a value-committed approach which emphasises the interactional relationship that the sociologist shares with his subjects of study.

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[1] Ibid P.502.

A similar idea to that advanced by Gouldner is expressed by Main in his explanation of the essentially different modes of perception or thought to be found within psychiatry. He seeks to explain how the psychoanalytic viewpoint differs in conception and method from medically or behaviourally-oriented psychologies. Psychoanalysis is said to be directed at "what man experiences within himself; that is with his inner subjective processes. It does not (as do the behaviouristic psychologies) take man as the object of observation, but views him as a subject of experience which is to be illumined and studied. It is (thus) concerned with psychic reality".[1]

Main argues that the objective-subjective dichotemy in psychiatric theory is based upon two oppositional modes of thought. "Diacritic thinking concerns inanimate things and deals with all phenomena as if they were inanimate because it cannot sense living. It therefore, has to deal with phenomena drawn from living creatures as if these phenomena were inanimate, single and separate".[2] The 'diacritic organisation' is centred around the body's sensory organs which manifest sense impressions in cognition and conscious thought.

Coenaesthetic perception on the other hand, derives from bodily impressions and emotions and is concerned with the sensing of total experience 'from within within'. It is subjective in nature and unrelated to the processes of the intellect. It is thus concerned with subjective awareness. Empathy, or sensitive identification with the experience of another, is the principle feature of coenaesthetic perception.

Diacritic thinking is said to be characteristic of most intellectual pursuits in which logical reasoning is utilised in the rational

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1 Ibid P.504.

2 Ibid P.505

pursuit of knowledge. Main states that this mode of thinking "is seen at its clear and emotionless best in mathematics and higher physics" and is common to traditions of Western learning "which prizes the intellect, logical functioning, accuracy of perception and academic achievement".[1]

Traditions of teaching in psychiatry are said to over-emphasise the importance of diacritic thinking with the result that the student is taught to regard the origins of psychic processes as lying 'outside the self'.

By virtue of the transference that is established in the psychoanalytic encounter, psychoanalysis retains a unique form of subjective involvement. The psychoanalyst's mode of interpretation of psychic phenomena rests upon a subjective appreciation of another person's experience. Whereas, most psychiatric methods are based upon diacritic modes of thought, in psychoanalysis it is the coenaesthetic element that Main regards as central to the understanding of the analysands experience.

It is significant to note that he goes on to explain that although coenaesthetic thinking is the only way that man can gain access to the psychic experiences of another, for the psychoanalytic method to be complete, two other processes need to be taken into account. This can best be illustrated by looking at his conceptualization of the psychoanalytic method as a process.

Element 1 involves the subjective appreciation of another person's experience; element 2 is the objectification of the experience by submitting it to the thought, logic and scientific conceptualising of

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[1] Ibid P.506.

the diacritic organisation; finally, element 3 involves a 'reality test'; the experiment of interpretation.

The psychoanalytic method, therefore, is a process of becoming subjectively appreciative of mental phenomena, while allowing for objective reality testing of these phenomena. In this way, the procedure is said to be unique in science. Main does not view the utilisation of subjective procedures as being inappropriate to the special 'science' of psychoanalysis so long as the process includes all three of the above elements. He therefore avoids the criticism that diacritic and coenaesthetic modes of thought can be interpreted as a dichotemy of objective and subjective forms.

There are certain similarities between these ideas of process and those expressed by proponents of the existential-phenomenological school.

The influence of existential ideas upon social scientific thinking is less noticeable in choices of analytical methods or areas of study than in modes of conceptualisation of particular questions. Generally, speaking, the existential thinker denies the individual the opportunity of viewing the phenomena of experience in terms of dualities or dichotemies by insisting on the primacy of immediate awareness. Being-in-the-world implies a realisation of one's 'reality' in the here-and-now; that is, one is conscious of emerging and changing, of becoming, and of being. Traditional philosophy's concern with finding 'essences', in the sense of immutable principles, logical laws, 'positive truths' and so on, implies that reality can be separated into discrete parts with laws governing them. Thus in the behaviouristic psychologies for example, human beings and their 'reality' have tended to be analysed in terms of forces, drives, and conditioned reflexes.

Existential philosophy on the other hand emphasises that 'existence precedes essence', or in other words, reality is not the object of thought, but is instead experience of consciousness in actual life. For the existential psychologist, behaviouristic analysis is a mode of reification since "The more absolutely and completely you formulate the forces and drives the more you are talking about abstractions and not the existing, living, human being".[1]

Rogers has expanded upon this argument by presenting it in the now-familiar form of a dichotemy of subjective and objective methods of study. Psychology, he argues, is now manifesting two divergent trends. The first is the 'objective' trend which is characterised by reductionist theories, operational definitions, experimental conditions and so on. This approach, he argues, denies introspection, subjective transactions, allows for the definition of 'self' as an object, asserts that understanding is external to the individual, and finally reverts to diachronic reasoning by holding that the future is determined by the past.

The oppositional trend, the existential model, is said to be concerned with the 'whole spectrum of human behaviour' in all its manifestations and as a form of psychotherapy its medium of expression lies in a "humanistic, personal encounter in which the concern is with an existing, becoming, emerging, experiencing being".[2]

In existential analysis, unlike Freudian analysis, the analyst does not set out to maintain a sense of 'distance' from his client, but rather approaches him as "an existential partner with whom he must share the totality of existence".[3]

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1 May, Rollo (ed.) Existential Psychology Chap.1 (May) pp.14-17 Random House, 1961.

2 Rogers C. Two Divergent Trends in R. May (ed.) Existential Psychology Chap.5 Ibid. p.86.

3 Ruitenbeek H.M. Psychoanalysis and Existential Philosophy Clarke, Irwin & Co. Ltd., 1962 p.XXI

The existential thinker then, is concerned with the ontological nature of reality not with the epistemological status of the knowledge particular to his field of enquiry. The origins and validity of knowledge, and the ontological quest for a deeper understanding of reality are, for the existentialist, fused in the moment of consciousness.

It is in this conception of immediate awareness that existentialism overcomes the problem of subject - object dualism. Ruitenbeek explains that existential psycho-therapy is in no way removed from the philosophy of existentialism because both are concerned with crisis; "one with crisis as characteristic of the human condition, the other with the individual-in-crisis".[1] This is a crisis resolvable only through the individual's immediate awareness of the ever-present, danger of his Being dissolving into Nothingness.

Both existential philosophy and psychotherapy, therefore, "endeavour to understand man by cutting below the cleavage between subject and object which has bedevilled Western thought and science since shortly after the Renaissance".[2]

It is hoped that by now the reader will appreciate the importance of elucidating the question of subject - object dualism in sociology and psychiatry. Although the writers referred to in the course of this discussion are not wholly representative of all the major schools of thought within the two disciplines, they nevertheless bear witness to the growing diversity of approaches and philosophical viewpoints that characterise the contemporary development of the human 'sciences'.

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1 Ibid P.XX

2 May R. (ed.) et al: Existence. N.Y. Basic Books 1958 P.11 in H.M. Ruitenbeek. Ibid P.XX

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CHAPTER 3

SOCIOLOGY IN PSYCHIATRY

INTRODUCTION

In recent years a number of attempts have been made to establish the sociological study of mental disorders as a distinctive sub-discipline within general sociology.

Some of the titles that have emerged during the course of this period of evolution bear witness to the difficulty that sociologists face in attempting to link two traditionally separate 'sciences', psychiatry and sociology, at a time when they are both engaged in efforts to clarify central theoretical and methodological issues.

For example, Bastide[1] refers to a 'sociology of mental disorder', Robertson[2] to 'sociology and the study of psychiatric disorder', Schatzman and Strauss[3] to a 'sociology of psychiatry', Kirson-Weinberg[4] to 'psychiatric sociology' or 'the sociology of mental disorders', Clausen[5] to a 'sociology of mental disease', and Dufrancatel[6] to a 'sociology of mental illness'.

Even if one accepts that these titles describe a general approach to the study of mental health and disorder, it is nevertheless clear that

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1 Bastide R. The Sociology of Mental Disorder. Routledge & Kegan Paul, 1972.

2 Robertson A. Sociology and the Study of Psychiatric Disorder. Sociological Review, 17, pp.377-397, 1969.

3 Schatzman L. & Strauss A.A. Sociology of Psychiatry: A Perspective and Some Organising Foci. Social Problems Vol.14, 1966-7 pp.3-16

4 Kirson-Weinberg S. The Sociology of Mental Disorders: Analysis and Readings in Psychiatric Sociology. Staples Press, London 1967.

5 Clausen J.A. Sociology of Mental Disease, in Freeman H.E. et al. Handbook of Medical Sociology. Prentice Hall N.J. 1963 pp.145-169

6 Dufrancatel C. The Sociology of Mental Illness Current Sociology. XVI (2) 1968.

fundamental differences exist between sociologists' conceptions of what should constitute the subject matter of a sociology of psychiatry.

During the course of this chapter it will be suggested that some of these differences derive from dualism in the theory and methodology of the social sciences and furthermore, that dualistic thinking may already have limited the contribution that sociology can make to the study of mental disorder.

On examination of the six works mentioned above, one is continuously struck by the sociological distinction between epidemiological and aetiological forms of enquiry. Generally speaking, epidemiological approaches are concerned with analysing 'rates' of behaviour, through quantitative analysis. The social epidemiologist asks whether specific behavioural continuities are indicative of social causation, and his task consists in fact-finding through the analysis of trends, regularities and statistical implications. The epidemiologist thus tends to maintain an 'external' position with regard to his subject matter.

Aetiological studies on the other hand are concerned primarily with finding and elucidating the causes of behaviour.

The search for causes in sociology has traditionally been viewed as problematic owing to methodological difficulties such as isolating dependant and independent variables, avoiding bias in the selection of factors for further analysis, and so on. It is hardly surprising therefore, that few sociologists have attempted to isolate causes of behaviour in a systematic fashion deriving from specific models of man or action.

The general tendency amongst sociologists in fact has either been to shy away from the question of causation, or to assume the existence of causal regularities in the formulation of research hypotheses.

The controversy over the sociological search for causes is not a new phenomenon. For a period of years during the later 1950's and early 60's, some influential American sociologists were involved in a debate over the question of whether Functionalism could provide general sociology with a viable working alternative to causal analysis, or whether it was in itself a disguised form of teleogical enquiry.[1-4]

Functionalists have tended to uphold the view that relationships between social events can be analysed and understood in terms of the functional interdependence of social system variables. To be able to say that 'y is a function of x' rather than saying 'x causes y' is an appropriate way of avoiding the criticism of monistic causal assumption. If the components of any system can be identified and shown to be reciprocally inter-related in a state of dynamic equilibrium, the task of establishing causes becomes secondary to the task of assessing functional relationships between variables.

As teleological forms of enquiry were seen to be problematic for functionalist sociology similar problems began to come to light

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1 Davis, Kingsley The Myth of Functional Analysis as a Special Method in Sociology and Anthropology. American Sociological Review 24, Dec. 1959, pp.757-772.

2 Dore A.P. Function and Cause. American Sociological Review, 26, Dec. 1961 pp.843-853.

3 Theodorson The Uses of Causation in Sociology.

4 Cohen P.S. Modern Social Theory. Heinemann 1968.

within general sociology. Even if they admitted that functional analysis involved disguised teleological assumptions, functionalists still had to deal with the criticism that their theoretical premises were too vague because they involved the generalised notion of 'causal pluralism'.

The 'aetiology' debate has had a considerable influence upon the development of a 'sociology of psychiatry'.

A diagramatic classification of the works of the six chosen writers may perhaps facilitate an understanding of their similarities and their differences. The vertical axis contains the names of the writers, and the horizontal axis, the analytical categories relating to their works. (Figure 1).

The six writers referred to have been chosen for the sole reason that they refer directly to a sociological study of psychiatry or mental disorder. It is recognised that other writers have contributed towards this field, but their contributions must be viewed as peripherally significant and will be discussed at the end of the chapter.

The five categories along the horizontal axis were chosen because they provide the basic information about each writer's conception of his field of study. Examination of the categories should enable us to make a simple, though effective comparison of the different points of view.

(i) Theoretical Models

The most important feature to emerge from an analysis of this category is the disparity between the formal titles given to the fields of study and what these various models actually purport to do.

The reason for the disparity lies in the attempt, by all of the six writers, to systematise their views by claiming to create a distinct

FIGURE I

	Theoretical Model	Methodological Approach	Object or Subject of Study	Sociologist's Stance	Who (if anyone) studies causes?
Kirson-Weinberg	Psychiatric Sociology The study of mental disorders as social phenomena.	Epidemiological. Do social factors indicate cuases of disorder in social processes?	Person(ality) in interaction with disruptive social environment.	Observer Information collector Indicator of causal process. External role/ Objective.	Social Psychiatrist: in liaison with psychiatric sociologist
Robertson	Sociology of Psychiatry. Interactionist: Study of self as a product of social experience.	Aetiological Creation of a taxonomy linking role of social environment in psych-aetiology to psychiatric symptomatology.	The 'self' as a product of social interaction.	Subjective involvement as actor defining the situation in which he is involved.	Sociologist: analyses relationship between self concept and types of psychiatric impairment.
Schatzman & Strauss	Sociology of Psychiatry. The academic study of Psychiatry as a discipline: not the study of mental disorder.	Epidemiological. How psychiatry works: Classification and elucidation of psychiatric processes.	Sociology as professional aide to psychiatry.	Consultant: providing advisor service to psychiatry.	Psychiatrist: aided by sociological information and advise.
Dufrancatel	Sociology of Mental Illness. Taxonomic study of Sociology's utility in defining the field of psychiatry and m. disorder.	Epidemiological/ Taxonomic Introspective look at Sociology as one of 4 possible modes of involvement with psychiatry.	Preliminary attempt to discover relevant place sociology in the study of mental disorder.	(Dependant upon whichever approach is adopted)	Sociologist: Providing that he separates his analytical methods from those of the medical profession.
Bastide	Sociology of Mental Disorder. Structuralist approach. Madness as defined by the collective conscience.	Structuralist: Sociology unites epidemiological & aetiological factors in notion of madness as collective representation of social disorder.	The isolate within the social system: as defined by collective legitimations of sanity and insanity.	Systems analyst: discovering correlations not causes between societal attitudes and deviant categories.	Non-applicable. Causation is subsumed under heading of collective representations. Functionalist.
Clausen	Sociology of Mental Disease. Disease model of m. disorder. Further development of social psychiatry: sociological exposition of correlates of disease.	Epidemiological. Systematic study of distribution and correlates of mental 'illness.'	Classification of illness 'types' providing 'clues' of multifactorial causation.	Expert: Classifies diseases and guides individual to professional attention.	Medical Profession: Mental disorders have largely organic/ physical causes - not field of sociologist.

sociological subspeciality dealing with the phenomena of mental health and disorder.

Even if the titles 'Sociology of Psychiatry' and Psychiatric Sociology' do not appear to mean different things, what they represent in practice are markedly different conceptions of the part that sociology can play in the understanding of psychiatry and mental disorder.

What then do these writers see as the purpose of sociology in psychiatric practice?

Kirson Weinberg (1967) views it as the study and elucidation of mental disorders as social phenomena. He advances a model of socially-induced pathology.

Robertson (1969) advances an interactionist model of social pathology, viewing his sociological purpose as the study of 'self' as a product of subjective social experience.

Schatzman and Strauss (1966) are not concerned with advancing models of disorder, they instead view their sociological purpose as studying the discipline of psychiatry and clarifying the professional status of the sociologist within this field.

Dufrancatel (1968) is initially concerned with the place that sociology, among other disciplines, could occupy in furthering society's understanding of mental 'illness'. His conception of 'sociology' however, seems to include these other disciplines, namely 'cultural anthropology' and social psychiatry. He is, therefore, concerned with defining an adequate model of 'sociology' in relation to the phenomena of mental disorder.

Bastide (1972) has outlined a sociological model of mental disorder based upon structural-functional theory. This model subsumes questions about the aetiology of disorders under the general heading of 'collective representations' of societal attitudes to mental disorder.

Finally, Clausen (1963) seeks to limit the involvement of sociology in the study of mental 'disease' by suggesting that "the greatest promise for the future is in the further development of social psychiatry, combining longterm systematic study of the distribution and correlates of mental illness with the design of more flexible treatment programmes.."[1] This confusing argument seems to imply that sociology should combine its capacity for the epidemiological study of mental illness with the therapeutic and preventive functions of social psychiatry.

What we have then is a series of differing views as to the nature and purpose of sociology's involvement with psychiatry. Differing viewpoints are valuable in the emergence of any new discipline, however, these particular models imply that there is little or no general consensus over (i) what constitutes the subject of study, or (ii) how these phenomena are to be studied in terms of their general claims to be representative of a distinctive subspeciality of sociology.

(ii) Methodological Approaches

Only Robertson out of the six writers in our sample stresses the importance of establishing, sociologically, the causes of mental disorder.

He states simply that "valid Sociological generalisations about

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[1] Clausen J.A. Op Cit. P.163.

psychiatric aetiology require a model of society which links the individual more directly to his cultural environment and which thereby permits more direct testing of the processes presumed to be influential in the causation of mental breakdown".[1]

This 'model of society' to which he refers, would link the role of the social environment in psychiatric aetiology with identifiable forms of psychiatric symptomatology. The Sociologist, therefore, plays an essential role in the identification and classification of the causes of mental disorder.

Bastide's structuralist sociology bears a greater resemblence to Robertson's ideas than to those of the other four writers. Both writers assume a link between the identification of 'self' and the meanings and collective representations implicit in social interaction. Whereas Robertson seeks to establish the origins of psychiatric aetiology, Bastide only infers the importance of causation through the discovery of correlations between societal attitudes to mental disorder and the processes by which individuals become isolated and branded by society as 'insane'.

Epidemiological studies are largely concerned with estimating the amount or assessing the incidence of mental disorder and from these findings, indicating causal regularities or trends. Kirson Weinberg for example states that the epidemiological distribution of mental disorders indicates <u>where</u> stresses are allocated and <u>what</u> social categories of persons have become emotionally disturbed or disordered in the socio-economic structure. "Sociological enquiries should determine the

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[1] Robertson A. Op Cit P.383

extent to which social factors indicate social causation". And by "successively isolating the crucial factors as indicators of mental disorders the causal social processes can become more circumscribed".[1]

Similarly, Clausen views the epidemiological purpose of sociology in this field as the "systematic study of the distribution and correlates of mental illness".

It is interesting how Kirson-Weinberg distinguishes "Psychiatric Sociology' from 'Social Psychiatry'. Only the latter he says, is directly concerned with the study of the social aetiology of mental disorder since only psychiatric training enables an individual to understand the relationship between the causes of breakdown and the procedures adopted to deal with it. The Sociologist is, therefore, seen as an 'information provider', whose field of enquiry is separate from, though complimentary to, that of social psychiatry.

The separation between epidemiological and aetiological approaches to mental disorder reflects the same preoccupations with the questions of value-neutrality and objectivity as were mentioned in the foregoing chapters.

Psychiatry emerged as a branch of medicine at a time when models of man and pathology reflected the view that the origins of disease lay within the individual organism, and hence the way to deal with the symptomatology of disease was through procedures developed or adopted by the medical sciences.

Despite the renewal of interest in the social determinates of mental disorder psychiatry still retains many of the characteristics of the formal medical approach to human pathology.

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[1] Kirson Weinberg S. Op Cit P.

"Given this climate of opinion, it is perhaps not surprising that sociologists have shown some reluctance to become involved in the study of psychiatric disorder. The serious conceptual and methodological problems which dog aetiological research in psychiatry may also serve to dissuade the potential researcher from entering this arena".[1]

Robertson quotes a number of examples of how sociologists, having become disheartened by the conceptual problems of aetiological research, turn away from this form of enquiry to engage in either epidemiological research of studies of the functioning of institutions such as mental hospitals.

Wardle, for example, has expressed the opinion that in the absence of unequivocal proof of a relationship between sociological variables and psychosis, the contribution of sociology to psychiatry "is likely to be greatest in attempts to understand and change public attitudes towards the mentally ill rather than in endeavours to identify presumed aetiological links".[2]

Dohrenwend is quoted as saying that before sociologists can conduct effective research into the epidemiology of psychiatric illness they must come to some agreement on the problem of defining a psychiatric 'case'.[2]

Robertson then goes on to quote Schatzman and Strauss who claim that "it would be much more fruitful if more research were done about psychiatry than in it, or for it..."[3]

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1 Robertson A. Op Cit P.377

2 Robertson A. Op Cit P.378

3 Schatzman L. Strauss A. Op Cit 1966 (Robertson P.378)

They argue that sociologists should avoid entanglement with assumptions containing ideological directives and should stand outside of psychiatry in the role of professional observers or consultants. Good research, in their view, is a public endeavour, therefore, by being public-minded, the sociologist can serve the public to its advantage.

"A Sociology of Psychiatry would in the last analysis", they say, "be concerned with who understands what about mental disturbance, and with what consequences for the discovery, handling and treatment of disturbance by those within psychiatry as well as by all those who might avail themselves of psychiatric practice".[1]

Robertson, despite being in substantial agreement with Schatzman and Strauss, still feels that sociology can make a distinctive contribution to an understanding of the causes of mental disorder. He states that the study of psychiatric illness demands prior consideration of two related sets of problems. The first concerns the conceptions that sociologists hold of the relationship between personality and social structure, and the second concerns the problem of verification of sociological hypotheses.

In the first case he asserts that "many of the ambiguities contained in the results of existing sociological research into the causes of mental disorder arise.... from the eclectic approach of researchers who start with a particular model of social structure and attempt to fit into this a model of personality which is guided by the basic assumptions of traditional psychiatry".[2]

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1 Schatzman L. Strauss A. Op Cit P. 8.

2 Robertson A. Op Cit. P.379 (my italics)

The conceptual models of sociology and of psychiatry are said to be different in the sense that psychiatry tends in general towards 'organic' models of pathology whereas sociology tends toward 'interactional' models of social action that view pathology more in terms of differential adjustment to societally prescribed goals and expectations.

The analytical separation between the 'person and his social environment' has resulted in a form of dualism, continues Robertson, which raises the "question of whether one holds individual behaviour to be determined by the pressures from a social environment which has an existence of its own over and against that of its individual members; or the patters and regularities of social interaction to arise from the autonomous actions of individuals pursuing similar goals".

Robertson's second case, which concerns the problem of verification, stresses the difficulty of developing a theory which is both sociologically relevant and at the same time amenable to empirical testing. This difficulty, he says, finds its origins in "the longstanding ambivalence of the relationship between sociology and positivism"[1] - an issue to which we have referred a number of times in the previous chapters.

Not surprisingly, we find that Robertson's basic theoretical position bears a phenomenological hallmark. He concerns himself with "the study of social behaviour at a phenomenological level, studying the significance which individuals subjectively attach to their own and other peoples behaviour". This involves "the assumption that the most useful path to understanding the role of the social environment in psychiatric aetiology lies in the development of a classificatory system

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[1] Robertson A. Op Cit. pp.378-9

in which... different types of value system and related variables are correlated with psychiatric symptomatology.."[1]

(iii) Objects or Subjects of Study

(iv) Sociologists Stance

(v) Who should study causes?

So far, the variables that constitute the focal interest of these six studies have been briefly touched upon in relation to their general theoretical and methodological contexts.

If we now view them in greater detail it should be possible to see how their differences reflect a basic lack of agreement over (i) what should constitute the subject matter of a sociology of psychiatry or mental disorder, and (ii) what theoretical grounds the choices of subject matter are made.

Kirson-Weinberg's emphasis upon the 'person' interacting with his social environment draws extensively from interactionist sociology. He views sociology's particular contribution to the study of mental disorder as the redirection of the object of study from the biological organism to the 'person in the social setting', one result of which has been the change in direction of interest from studies of the mental hospital to 'community psychiatry' or the relationship between the individual and the community.

The Sociologist in this formulation nevertheless remains external to the therapeutic procedures of psychiatry. His role is one of providing information about the 'how much', 'where', 'when', and 'to whom' of mental disorder, leaving the 'why', 'because' and 'what to do'

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[1] Robertson A. Op Cit P.392

questions to the psychiatrist. In answer to the question, therefore, who should study causes?, Kirson-Weinberg would argue that the psychiatrist does, in consultation with his professional ally, the sociologist.

Surprisingly, Robertson's concept of 'self' as a product of social interaction, differs only slightly from Kirson-Weinberg's concept of 'person'. The main difference in approach is not found at this level but at the level of definition of the theoretical purpose of sociology in relation to psychiatry. As we have already seen, Kirson-Weinberg supports an epidemiologically oriented 'psychiatric sociology', whereas Robertson feels prepared to commit his 'sociology of psychiatry' to the task of establishing the social causes of mental disorder. In other words, Robertson, through his exposition of a social model of mental disorder, assumes one of the roles that the psychiatrist has traditionally presumed unique to his profession, that of "diagnosing" the origins of mental disturbance.

Against the 'information-providing' role that Kirson-Weinberg's sociologist plays, Robertson's sociologist sees himself as one of the actors, subjectively defining the situation in which he finds himself, as he comes into contact with the subjects of his studies.

The 'interactionist frame of reference', he explains enables the sociologist to separate 'situational' studies from 'aetiological' studies, in the sense that the former are concerned with situations in which individuals are immediately involved, with particular reference to the extent to which these impose regularities on behaviour, whereas the latter "look at the person as the end-product of key experience in sets of structured interactions".[1]

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[1] Robertson A. Op Cit. P.387

Robertson confidently advances what he considers to be water-tight criteria for a sociology of mental disorder. These are threefold:-

1. Psychiatrically it should explain why sick individual's behave as they do.
2. Sociologically it should clearly offer an explanation of pathological behaviour in terms of the social environment of the individual.
3. It should meet the scientific requirement of testability.[1]

In other words, a Sociology of Mental Disorder can advance a model that accounts for the social origins and nature of mental disorder as well as satisfying the necessary criteria of 'scientific' validation.

It is not our task here to analyse in depth the implications of such an approach since our immediate purpose is to make a comparative assessment of a selection of approaches and from this to ascertain whether a sociology of psychiatry or mental disorder can be said to have the status of a unified discipline.

It should be sufficient to say that Robertson's sociological model is incomplete in the sense that it does not provide any guidelines for the care or 'treatment' of the mentally disordered. If a sociologist can explain psychiatrically why sick individuals behave as they do, and if he can account sociologically for the origins or causes of mental disorder, then surely the next step involves the care of the disordered? This, of course, raises an important point that will be dealt with later, that of establishing whether sociology can or should assume a therapeutic function.

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[1] Robertson A. Op Cit. P.391

Schatzman and Strauss hold to a markedly different conception of the object of a sociology of psychiatry than that advanced by Robertson. They claim that sociology should be viewed only as a professional aid to psychiatry.

They do not support sociological involvement in psychiatry and it appears that research for psychiatry is equally undesirable.

Dufrancatel on the other hand does not claim to be able to establish a definition of the object of study for a Sociology of Mental Illness. He argues instead that it is a diverse field in which many different approaches to the problems of mental disorder are subsumed under such subject-headings as 'cultural anthropology', 'medical sociology' and 'social psychiatry'. This diversity stems, he argues, from the impossibility of defining the epistemological status of the field. Empirical research does not provide the answers to some of the more taxing theoretical questions such as how causes can be established or why one form of treatment is therapeutic whereas others are not.

This situation he argues, has led to studies of mental disorder being separated into two groups. The first deals with those studies which utilise psychiatric definitions of mental illness whilst attempting to find socio-cultural factors which account for their origins. The second deals with those studies which examine the social conditions which give rise to definitions of sanity and madness. The first group faces the problem of subordinating sociological insight to medical traditions of thought, whereas the second group places the sociologist in the position of having to adhere to a definitive concept of 'normality' in order to be able to assess the validity of other definitions.

He does not argue that the sociologist should avoid making causal statements concerning mental disorder, only that to do this should involve

the clear separation of sociological methods of analysis from those of psychiatric medicine.

In a manner similar to that of American structural-functionalism, Bastide argues that "the mentally ill cannot be located within society as a whole unless we recognise the structures of deviant systems in relation to the structure of the main system".[1] Furthermore, "a person is mad only in relation to a given society; social consensus defines the fluctuating boundary between the rational and the irrational".[2]

The object of study in this case is the 'isolate' within the social system viewed in terms of how this individual reflects collective definitions of sanity and madness. "History reveals that delusions are not merely the activity of sick people, but collective constructions in which society plays at least as great a part as the sick person himself".[3]

The role of the sociologist then appears to be that of a 'systems analyst' who construes his task as one of discovering correlations between societal attitudes to mental disorder and 'categories of deviance'. Since social disorganisation and individual disorganisation are aspects of the same reality, what the sociologist analyses is the cumulative effect that individual pathology can have upon the total system.

As is generally the case with systems theories, questions of cause and effect tend either to be ignored or subsumed under the category of the functional interdependence of parts of the system. Bastide's structuralist sociology is no exception to this rule.

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1 Bastide R. Op Cit. P.203

2 Bastide R. Op Cit. P.195

3 Op Cit. P.206

His 'Sociology of Mental Disorder' is advanced as a complete theory accounting for the nature, origins and social management of disorder. Unlike the other five approaches, this approach seems to imply that the sociologist of mental disorder can do more than isolate causes; he can also be actively involved in the organisation if not the administration of therapy, for therapy, of whatever nature, he argues, is only valuable "if it helps to establish and remodel the sociological relationship between two people".[1]

The last writer to be discussed, Clausen, is perhaps most representative of traditional medical sociology in the sense that the conceptual models as well as the terminology of psychiatry are incorporated in his interpretation of Sociological research. He appears to view the sociologist's purpose as that of studying the incidence of medically defined disorders in relation to socially-relevant variables, such as ecological distribution of population, socio-economic status and so on.

He defines epidemiological research as "the study of the distribution and correlates of diseases in time and space", and it is said to serve two important functions: "it frequently provides clues to the complex, multi-factorial causation of diseases whose aetiology has not been definitely established and provides basic information on the needs for disease control and treatment programmes for a given population".

He goes on to say that to be of value "such research requires that experts be able to classify instances of the disease with a fair degree of certainty and that most persons suffering from the disease come to the attention of these experts".[2]

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1 Op Cit P.180

2 Clausen J.A. Op Cit. P.150.

These 'experts' seem to be an amalgamation of psychiatrists and sociologists, although it is uncertain from the article to whom Clausen is actually referring. It may be that the sociologist is able to identify certain illness categories from his research which enables him to make the relevant medical agencies aware of their field of intervention. In this sense the sociologist 'guides' people to 'expert' help.

CONCLUSIONS

One of the most obvious conclusions that can be drawn from the foregoing analysis is that there is no real consensus over the kinds of questions that constitute a field known as a Sociology of Psychiatry or Mental Disorder.

Although the sample of six writers is small it is nevertheless a useful example of the kinds of differences of opinion over theoretical issues, that exist amongst sociologists who claim to be laying the foundations of a new sub-discipline.

This lack of consensus may reflect a degree of uncertainty amongst sociologists concerning the point at which sociology ceases to be a fact-finding social science and begins instead to challenge the central premises of psychiatry.

Where one draws the line between sociological investigation and sociological intervention seems to be determined by the conception of the purpose of sociology held by sociologists of varying schools of thought.

One could argue, for example, that, if ones model of science incorporates the view that good sociological research demands that the sociologist remains external to his subject matter in the sense of not

allowing his value predispositions to influence either his data, or his role, it is more likely that he will carry out epidemiological research on behalf of psychiatry, rather than research in psychiatry.

Holding to a model of science such as this would enable the sociologist to view sociology and psychiatry as two separate though complimentary disciplines. In this sense, 'separate' should be taken to mean 'having exclusive fields of enquiry'.

In recent years, however, it has become evident that some sociologists and some medical practitioners do not view the theory and practice of psychiatry as being exclusive to that discipline.

Kaufmann illustrates this by saying that "for the most part professionals from the behavioural and social sciences have been attacking what they call the "medical model" of mental illness. These attacks range over a broad spectrum. At one extreme there is a complete denial that the medical model is relevant to the manifestations which the psychiatrist would consider to be within his realm".[1]

At the other end of the scale, (to which Kaufmann does not devote his attention) there is considerable acceptance of the complementarity of medical and social theory in the understanding of mental disorder.

What is significant here is the range of opinion that exists amongst sociologists concerning the role of sociology in psychiatry. One needs only to look at some of the titles of the various medical and sociological subspecialities to realise how far the two fields have become intertwined. We have, for example, 'medical psychiatry', 'medical sociology', 'social psychiatry', 'psychiatric sociology' and 'community psychiatry', not to mention the various 'sociologies of psychiatry', mental disorder and so forth.

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1 Kaufmann M.R. Psychiatry: Why 'Medical' or 'Social' Model? Archives of Gen. Psychiat., Vol. 17, No.3 Sept. 1967, P.347

The extent to which sociological concepts, theories or methodology are incorporated into these approaches to mental disorder seems to depend upon the degree of acceptance of social factors in the origin and management of these disorders.

The greater the emphasis upon medical models or concepts, the smaller is the emphasis upon their social counterparts. Kaufmann, for example, having summarised what he considers to be the major features of both medical and social models of mental disorder concludes by saying that "The social model as conceptualised by its proponents represents but one facet of the medical model as it has evolved".[1]

Further reading of his article makes it abundantly clear that his commitment to the medical profession and its theories of pathology does not allow him to judge the 'social model' in an unprejudiced manner. After admitting that there are still many unanswered questions concerning the relationship between the social sciences' and psychiatry, he does not think it inconsistent to argue that medicine is in a strategic position for the integration of biological and sociological knowledge because "in the ranks of the professions it is the physician more than anyone perhaps who must rely on the biophysical sciences and also deal daily with an abundance of psychosocial data relevant to the individual's adaptations".[2]

Whereas Kaufmann limits the independence of a social model of mental disorder by subsuming it under the general heading of a medical model, Szasz, as we have seen, rejects this latter model altogether claiming instead that mental 'illness' is a myth and that its behavioural manifestations are merely socially defined forms of deviance.

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1 Ibid P. 358.

2 Ibid P.352

Ruesch[1] on the other hand has a tendency to blur the whole question of medical or social areas of investigation by firstly defining psychiatry as a threefold perspective on mental disorder and secondly defining 'social psychiatry', one of the original three perspectives, as a multi-dimensional mode of study. 'Psychiatry' he argues, consists of psychological, biological and social orientations. 'Social Psychiatry' should be viewed in terms of 'activities', 'points of view', 'modes of information', and 'forms of abstractions'.

Its study areas (points of view) cover Sociological and anthropological issues, epidemiological and ecological conditions, preventive strategies, and 'therapeutic' forms of interventions.. Of the latter 'forms of Intervention', 'social therapy' is described as having six procedural methods (i) community psychiatry, (ii) group therapy, (iii) therapeutic community, (iv) family therapy, (v) occupational therapy (vi) social programming - all of which have their origins in, and are generally seen to belong to 'medical' psychiatry despite their 'social' orientations.

The extent of the confusion over the place of sociological concepts and theories in psychiatry becomes more and more noticeable as one works through the joint literature of sociology and psychiatry. Roman[2] has shown that during the past two decades there has been a growing recognition of the role of social factors in the development of behaviour disorders. He feels, however, that many potentially valuable contributions to psychiatry by sociology have not taken place because of

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1 Ruesch J. Social Psychiatry - an overview.

2 Roman P.M. Labelling Theory and Community Psychiatry. Psychiatry V.34 Nov. 1971 pp.378-390.

"pyschiatric indifference toward the existence of a bounded discipline of sociology". Furthermore, psychiatry, while integrating portions of sociological theory into its own models, shows no concern for the "inconsistencies between sociological and medical conceptions of psychiatric disorder".

Roman is of the opinion that many psychiatrists have come to assume that the concepts and methods of psychiatric sociology are a legitimate part of psychiatry's 'intellectual technology' rather than the province of sociology. This, he feels, is due to the absence of clear-cut boundaries separating criteria for those that 'do sociology' from those that 'do psychiatry'.

As a result of the lack of status that Sociologists' experience in relation to the psychiatric profession, "psychiatric sociologists (may) have accidentally, but in large part "sold out" their potential professional mandate such that their future roles in relation to psychiatry may be largely comprised of institutional description, peripheral criticism and methodological consultation".[1]

It was suggested earlier that most sociological links with psychiatry tend to be of a consultative or information-providing nature. Sociological research <u>in</u> psychiatry is common; research <u>for</u> psychiatry quite usual, and research <u>about</u> psychiatry, particularly with reference to institutions such as hospitals, quite acceptable. In other words, sociologists are providing the psychiatric profession with a valuable, though <u>ancillary</u> service. Whether the accumulation of data and experience in the field is a sufficiently good reason for remaining external to the therapeutic procedures of medical science,

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[1] Ibid P.388

must depend upon sociologists' conceptions of the theoretical purpose of their discipline which will in turn determine the extent to whih they are willing to become involved in questions of aetiology and treatment.

Roman points out that since the late 1950's there has been a lessening rather than an increasing concern amongst sociologists with questions relating to the aetiology of mental disorder. During the 1920's and 30's the 'Chicago School' developed an approach in which mental disorder was seen as being one of the important dimensions of social pathology.

At a time when the biological sciences were seen to be failing in their attempts at verifying aetiological hypotheses based upon organic, biophysical models of disease, sociology, under the influence of Sullivan, Horney and other social psychologists began to gain recognition as an important new source of explanation of psychiatric pathology. Social factors that could be shown to play a significant role in the onset of psychiatric disorder began to be viewed as valuable explanatory variables. The stage was thus set for the opening up of social epidemiological research. The indication of factors bearing a relationship to mental disorders amongst varying populations soon became Sociology's justification for entering the traditionally exclusive field of aetiological research.

Later studies such as those of Faris and Dunham[1] and Hollingshead and Redlich[2] into the relationship between social class and mental

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1 Faris R.E.L., Dunham H.W. Mental Disorders in Urban Areas. Univ. of Chicago Press 1939.

2 Hollingshead A.B., Redlich F.C., Social Class and Mental Illness. Wiley 1958

disorder are representative of the initial enthusiasm that followed the introduction of sociological approaches to the study of mental disorder. Unfortunately, this enthusiasm, turned out to be relatively short lived. For a number of reasons epidemiological studies failed to indicate accurately enough the 'social causes' of disorder.

Firstly, they gave rise to a "multitude of aetiological hypotheses which collectively overestimated the actual amount of pathology in the population".[1] Secondly, the breakthrough in establishing the social aetiology of mental disorders most probably did not occur because sociologists "failed to locate either necessary or sufficient causal conditions"[1] Lastly, and perhaps most important of all, the failure to locate causes of a definitive nature was "not due to inadequate theory or crude methodology but rather (to) the use of the disease model which initially provided the assumption that a single cause or clearcut sequence of aetiological mechanisms could be located".[2]

The mistake of epidemiological research lay in the assumption that social correlates of illness explain disease rates. As Robins has suggested, social factors have been mistakenly assumed to be <u>independent</u> variables whereas 'the disease' has traditionally been viewed as the <u>dependent</u> variable.[3] As a result of this situation, sociologists find themselves predisposed towards accepting medical definitions and models of disorder. More recently, reactions to the ascription of an ancillary status to Sociology have become notably more aggressive amongst sociologists working in the psychiatric field.

Robins quotes Feldman as saying "It is unfortunate that social scientists working in the field of health should devote all their energies

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1 Roman P.M. Op Cit. P.379

2 Roman P.M. Op Cit. P.380

3 Robins L.W. Social Correlates of Psychiatric Illness: Can we tell Causes from Consequences? Res. Pub. Assoc. Res. Nerv Men. Dis. 47, 1969, P.154

in trying to explain medical phenomena in terms of social processes... It might benefit both social science and medicine if more frequently the orientation were reversed and attention were paid to the physiological factors bearing on the social environment".[1]

This statement is less important as an expression of frustration about the theoretical status of psychiatric sociology then as an example of the 'politics' of the humanistic disciplines. After all, if social aetiology in mental disorder could be shown to be causally consistent, sociologists would probably claim a larger share in the diagnosis of mental disorder. The continuous emphasis upon epidemiological correlates of disorder however, has left the social sciences with a legacy of multiple, hence non-specific causes, leaving field workers vulnerable to the criticisms of medical personnel who need only to fall back on their traditionally accepted models of disorder to appear credible. As Robins points out, "When we cannot disentangle social causes from accidental correlations, we treat them all as possible causes".[2]

The status of medicine as a profession is undeniably stronger than that of sociology in contemporary society. In fact, a recent study lables medicine as an 'institution of social control', in which society is seen to have become obsessed with problems of ill-health, and in which daily living is becoming more and more subject to 'medicalizing' influences.[3]

"Doctors, who do not conspicuously blot their copybook" argues Margot Jeffreys in a different article, "enjoy high status; possessing it, they do not have to worry about it except to the extent that they need

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1 Ibid P.154

2 Ibid P.156

3 Zola I.K. Medicine as an Institution of Social Control. Sociological Review Nov. 1972, pp.457-504

to defend it against competitive claims for recognition by other professional groups".

On the other hand, "Sociologists, with considerably less status, are more conscious of its absence when confronted with those who possess it, and consequently are more inclined to aggressive assertiveness... Positive steps must be taken, therefore, to ensure that sociologists and others who are contributing to medical knowledge... are given the status and career prospects which they would have expected if they had stayed within... their parent discipline".[1]

Jeffreys suggests that as long as social scientists are trained for work in medicine, medical personnel should be trained to work in Sociology as applied to medicine. For "if doctors generally had more of these sociological perspectives built into their training they might be less inclined to attribute their frustrations to the evil machinations of politicians, social workers, lay administrators and their own professional colleagues in other branches of medicine.."[2]

One of the important factors in the separation of sociological and psychiatric practice stems from the divergent philosophical traditions upon which they are based - a question to which we have already devoted time. This separation is referred to yet again by Lochen in his analysis of the relationship which sociology bears to medicine.

"It does not seem easy for medical doctors to accept that sociology does scientific and systematic work within completely different scientific traditions. Many of them discard the notion of a phenomenological or humanistic sociology. At the same time sociologists - probably in increasing numbers - reject the whole concept of a positivistic

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1 Jeffreys M. Sociology and Medicine: Separation or Symbiosis? Lancet June 7th 1969, P.115.

2 Ibid P.1113

science of society. We are, in other words confronted with the expectation of becoming a natural scientist".[1]

He continues by saying that sociology should not just be an accommodating intellectual activity, playing 'second fiddle' to medicine, but should instead critically examine the concepts and structure of medicine to see whether they 'fit' contemporary society or not. However, for sociology to reach its full critical potential requires not just organisational, or for that matter, theoretical changes; not just as these writers seem to suggest, a reversal of the trend whereby we encourage medical participation in sociology in order to enhance the professional status of that discipline, but a willingness on the part of sociologists to stick their necks out and challenge, if not seek to replace medical models, concepts and practices where the need is evident.

It has become too easy for medicine to describe its partial acceptance of sociological theories by subsuming them under the heading of 'eclecticism' while at the same time restricting sociology's role in medicine. Who can tell for example how far the developing trend in phenomenological psychology will influence, if not become representative of a new philosophy of intervention in questions of ill-health? How does the psychiatric profession feel about the mushrooming of non-medically based psychotherapy? And what kind of threat does the trend away from medical models of illness and positivistic models of man pose for the future of medical psychiatry?

Despite the continuing exclusion of sociologists by psychiatrists from areas of medical and psychiatric practice, as well as avoidance by many sociologists of specific questions pertaining to aetiology and

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[1] Lochen Y. Sociology and Medicine. Acta socio-medica 3, pp.161-168 Scandinavia 1971.

intervention, an awareness of the complementarity of the two disciplines does seem to be developing. Jeffreys describes this trend very succinctly: she holds that 'sociology's relationship to psychiatry is 'symbiotic' in that it is characteristic of an "intimate relationship between separate organisms, one of which may have been originally parasitic on the other, but by modification have been able to live together and derive mutual benefit from each other's presence".[1]

It is difficult to guage the extent to which these benefits are 'mutual', but the feeling that cooperation should be encouraged between the disciplines is gaining sympathy amongst a growing number of psychiatrists as well as sociologists. Lochen is probably over-optimistic in his assertion that we are entering an era of cooperation in which social science is becoming representative of a distinctive body of knowledge relating to questions of health alongside other bodies of knowledge, including medicine, <u>each bearing equal professional and intellectual status.</u>[2]

On the other hand, Zola's statement about the "insidious and often undramatic phenomenon accomplished by medicalizing much of daily living"[3] is meant as a warning to non-medical persons (which would include sociologists) about the influence that the medical profession is able to wield over the lay population.

By defining certain forms of behaviour as illness, and classifying illness as an undesirable state "the issue becomes not <u>whether</u> to deal with a particular problem, but <u>how</u> and <u>when</u>".[4] In other words, the medical profession is, by its propagation of organic, behaviouristic or

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1 Jeffreys M.J. Op Cit. P.1111

2 Lochen Y. Op Cit. P.163

3 Zola I.K. Op Cit. P.487

4 Op Cit. P.500 (Zola's italics)

'mechanical' models of disorder, predisposed towards helping the 'sick' who are so defined because they manifest symptoms, though often recognisable to the layman, only treatable by medically trained personnel. The theory and practice of medical intervention is thus a professional monopoly.

Since psychiatry is still viewed as belonging to the general field of medicine its methods of classification and diagnosis of illness types are naturally assumed to reflect the influences of its traditional associations with physical and psychoanalytic medicine. This does not mean that psychiatrists have not reacted favourable to new ideas advanced by social scientists, although it has meant that social scientists have been required to validate their theories and methods either in terms of assumptions and conceptual models already established in psychiatry, or by way of comparison with these assumptions and models. In the latter case, sociological hypotheses do not stand the test of scientific validation as readily as do those of medical science. As a result, sociological concepts and models are often branded as being 'subjective', which implies that they are 'unscientific', and hence unacceptable in matters of psychiatric intervention.

Since no precendent exists in contemporary society for diagnostic evaluation or therapeutic intervention of a sociological nature, Sociology, it seems, must be content with its ancillary status. Bastide's notion of the value of therapy being its propensity to remodel the sociological relationship between two people, seems to imply that psychiatry should not be dominated by a medically-inspired methodology. It must be admitted though, that the absence of any examples of how to remodel these 'sociological relationships' only serves to reinforce the view that psychiatric medicine only needs sociology to provide it with insight and information pertaining to socially induced pathology, and not to assume any responsibility for dealing with it.

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PART 2

IN SEARCH OF THE THERAPEUTIC MILIEU

CHAPTER 4

A BRIEF REVIEW OF THE ORIGINS OF SOCIAL MEDICINE

INTRODUCTION

It is often the case in the development of a discipline that a 'new' idea or innovative technique turns out to have its origins in an earlier period of history. The notions of 'therapeutic community', 'milieu therapy' and 'social medicine' are examples of such cases. One can find similar references to typologies of 'madness' alongside recommended methods of treatment as readily in the works of Graeco - Roman thinkers and chroniclers such as Plato and Hippocrates as in the published works of contemporary psychiatrists. Furthermore, there would seem to be no shortage of examples in earlier works of the notion of 'madness' being characterised as either a feature of the individual's psychobiological constitution or, a function of the individual's social situation or even a manifestation of the defining group's moral and social values. In other words, throughout history men have been aware that the criteria used to define madness cannot be drawn solely from observations of the ascriptive characteristics of the individual or alternatively from generalisations about the interactions between man and his social environment.

The nature-nurture argument which still finds considerable support today within the medical profession, found popularity also in ancient Greece and Rome. Rosen has commented upon the similarity, for example, between methods adopted by the Roman physician Soranus, and the Tukes

at the eighteenth century York Retreat, in the use of milieu therapy in the handling of patients with delusions and hallucinations.[1] Alternatively, the Hippocratic view that "all diseases have natural causes discoverable through the human mind[2] finds its modern- day counterpart in support for theories of organic or physical causation in mental disorders".

There are many examples in the history of medicine of how conceptions of madness have modified following changes in the belief systems of societies or influential social groups. Since we are primarily concerned in Part 2 with social medicine as a background against which to view the development of the 'therapeutic community' concept, attention will be focussed only upon aspects of medicine in the context of nineteenth and early twentieth century social thought.

The 'Moral Treatment' Era

The sixty years between 1790 and 1850 mark the period in which the foundations of modern psychiatry are said to have been laid. Changing attitudes towards madness in the seventeenth and eighteenth

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1 Rosen G. Madness in Society: Chapters in the Historical Sociology of Mental Illness P.132 19

2 Ibid. P.88

centuries reflected the influences of Rationalism upon European thought, exemplified, in the centralisation of policy in matters of health deriving from mercantalist notions of central government and administration.

Considerable emphasis was placed upon public accountability for the insane at the turn of the nineteenth century which has prompted a number of writers to suggest that the provision of care facilities was, in some ways, more 'humanistic' than at any time previously. What was it then about this period that justifies such as assertion?

The answer to this question depends to a large extent upon one's attitude towards the underlying motives of those involved in the administration of 'moral treatments'.

Szasz, for example, in his disucssion of the work of the American physician Benjamin Rush, states that the 'medicalisation of social problems and their coercive control by means of 'therapeutic' rather than punitive sanctions' stemmed in the case of Rush, from the belief that "the mind and the body are moved by the same causes and subject to the same laws".[1]

Mental illness was equated with social non-conformity, and in the tradition of the Enlightenment, non-conformity implied absence of Reason. Whereas, in the early eighteenth century absence of reason was treated as irresponsibility (Folly) and punished by incarceration in work-houses or cells, for Rush it represented moral disease which could be treated in any manner that the physician thought appropriate. Since the physician was able to assume the role of judge in questions of morals and social evils, he was viewed by many as protecting, in a paternalistic

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1 Szasz T.S. The Manufacture of Madness. Harper & Row 1970. P.139

manner, both the interests of the individual as well as of society. It was as a result of this change in the interpretation of madness as irresponsibility, to madness as (moral/social) 'disease' that the administrators of 'moral treatments' were convinced that coercive measures were compatible with the notion of humanistic care.

Binger is quoted as having remarked that "Control was the essence of Rush's therapeutic activity",[1] implying that the encouragement of self-control in the patient was not considered to be the purpose of therapy. What the physician did to the patient was more important than what the patient did for himself.

It is widely accepted that Philippe Pinel, the head of the Bicetre Assylum in Paris, was responsible for many of the changes in the practice of treating the mentally disordered during the early nineteenth century.

Although it appeared that these measures were carried through on humanistic grounds, Szasz is of the opinion that Pinel was in fact "an uncompromising advocate of psychiatric coercion", because he was not concerned with restoring the patients to liberty, but believed instead that "in a properly run madhouse, the patients should be so impressed with the overwhelming authority and power of the keepers that such crude methods of control should be unnecessary".[2] Pinel's use of intimidation and Rush's use of 'terror' were both considered therapeutic because they were thought to act "powerfully upon the body through the medium of the mind..."[3]

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1 Binger, C. Revolutionary Doctor: Benjamin Rush 1746-1813. N.Y. Norton 1966 in Szasz T., Op Cit. 1970 P.145

2 Ibid P.146

3 Ibid P.147

Foucault has reacted strongly to the notion that 'moral treatment' implied the use of humanistic methods of dealing with the mentally disordered. He argues instead that the abolition of constraint "substituted for the free terror of madness, the stifling anguish of responsibility".[1] In other words, as the madman was denied his right to be mad, he was forced to feel guilty about not 'getting better'. The implication that can be drawn from this is that Pinel and his contemporaries sought to impose a consensual view of morality upon the patient which was as coercive as former methods of constraint, because 'mental' liberty was being curtailed in place of physical liberty.. Madness was thus equated with an absence of moral responsibility, and it was assumed that society was best protected against the madman through the paternalistic attempts of physicians to return the 'morally misguided' to normality.

It is nevertheless the case that a number of experiments in the practice of 'moral treatment' did emphasise the importance of kindness and generosity in attitudes towards the disordered. For example, an American journal of 1847 described moral treatment as involving "the removal of the insane from house and former associations, with respectful and kind treatment under all circumstances, and in most cases, manual labour, attendance on religious worship on Sunday, the establishment of regular habits of self-control, and diversion of the mind from morbid trains of thought".[2]

Differential access to treatment by class, is implied in Perrow's description of a mode of 'moral treatment'. Drawing on documents of the period he describes how "patients had private rooms; there were

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1 Foucault M. Madness & Civilization: A History of Insanity in the Age of Reason. Tavistock 1967 P.247

2 Brigham Y. Moral Treatment of Insanity. American Journal of Insanity 6, 1847.

sitting rooms, games rooms, and a workshop equipped with tools; there were lectures on literature, history and natural science in the evenings; patients went for drives in the country and were free to fish, hunt, garden and assist in farm work. The patient was considered a part of the physician's family and existed in as normal a social environment as could be devised".[1]

The paternalistic atmosphere of this 'hospital' is evident, though it would appear that patients were not 'disturbed' to the extent that they required constant supervision. This may imply that only neurotic forms of disorder were deemed treatable by means of a 'sympathetic milieu' - a belief still prevalent in many 'therapeutic community' experiments.

The use of the 'therapeutic milieu' in treatment and rehabilitation of the mentally disordered was perhaps the only significant feature of the 'moral treatment' period in that it was respresentative of an unorthodox notion, namely, that by 'changing the environment you change the person'.[2] To say that these early nineteenth century physicians held to a 'social' model of psychiatric aetiology, however, would be to exaggerate as well as to misrepresent their notions of 'moral treatment'.

There are a number of reasons why such an idea was acceptable to a minority of physicians during this period.

The science of Bateriology had not yet developed and there was no acceptable theory of organic or biochemical degeneracy to explain the origins of psychiatric disorder. It had been hypothesised

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1 Perrow C. Hospitals: Technology, Structure and Goals. in J. Marsh (ed) Handbook of Organisations. Rand, McNally & Co. 1965 Chap. 22 P.918.

2 Ibid P.919.

(by Rush and others) however, that there was a link between physical and mental functions in human pathology and for this reason social as well as professional acceptance of this idea was forthcoming because Europe and America needed a Rational explanation of how to deal with the growing problems of social order and social hygiene in the face of rapid industrialisation and urbanisation.

The physician was becoming the 'new guardian of social conduct and morality',[1] assuming a paternalistic role in society. By judging mental disorder as a manifestation of 'moral disease' the physician could assume a 'fatherly' role in relation to his patients by offering them moral guidance. Whether or not this treatment involved physically coercive practices was of little relevance to the physician. It was nevertheless assumed that better guidance could be provided in surroundings which emphasised the importance of physical as well as moral hygiene which resulted in some hospitals attempting to avoid appearing like places of incarceration.

European governments during the first half of the nineteenth century assumed increasingly paternalistic roles in matters of public health and it was not uncommon to find physicians, politicians, academics and intellectuals jointly participating in activities dedicated to social change.[2] The terms 'social hygiene' and 'social medicine' date from the 1830's and 40's as does the general acceptance of the medical profession as the most appropriate group to determine policy in matters of health.

In 1847, Neuman stated that "medical science is intrinsically and essentially a social science" whereas Virchow optimistically claimed

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1 Szasz T. Op Cit. 1970 P.160

2 Rosen G. The Evolution of Social Medicine: in Freeman, Levine & Reeder; Handbook of Medical Sociology. Prentice Hall, 1963 P.31

that 'Medicine is a social science, and politics nothing but medicine on a grand scale".[1] The view that politics, economics, education and health were all basically interrelated, provided weight to the argument that moral behaviour was healthy behaviour and, therefore, the moral deviant was a sick member of a healthy society. Representatives of the Enlightenment taught principles of mental hygiene based on the training of the will and the sub-ordination of the passions to reason. As a result, mental disorder was considered to be a disturbance of reason. Thus in the search for the causes of disorder, loss of reason was ascribed either to physical origins or degenerate practices such as lesions in the brain or uncontrollable passions.[2] This may account for the growing interest shown at the time in brain surgery, human physiology and the function of the nervous system, alongside the attempts of those physicians mentioned to administer 'moral' treatment.

Medicine in the 1830's was still very much an unstructured discipline in a pre-scientific era. It was not until the 1870's that the major advances in the natural sciences accompanied by a growing emphasis on Positivism in scientific thinking began to reshape medical attitudes towards mental disorder.

The influences of German Romanticism on medical thought between 1800 and 1830 played a significant role in limiting the Enlightenment belief in man as a rational animal, substituting for it instead the notions of individualism and 'will' - an essentially irrationalist concept. The Romantics believed in dialectics and metamorphosis and they emphasised the importance of the unconscious in emotional behaviour. It was out of this tradition, in combination with, the medical scientific discoveries of the later nineteenth century that the dynamic psychiatries

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1 Rosen. G. (1963) Op. cit. pp 35 6

2 Ellenberger H.F. The Discovery of the Unconscious: The History & Evolution of Dynamic P ychiatry Allen Lane/Penguin Press 1970 P.197.

of Freud and his followers were to emerge.

Romanticism in medicine may well have provided another motive for the 'humanisation' of early nineteenth century psychiatry. In an interesting account of the work of the German physician Johann Reil (1759-1813), Ellenberger shows how physiological and moral treatments complemented each other to some extent. Reil insisted upon the term 'asylum' being replaced by 'hospital for psychic cure methods' and believed that institutions should be located in pleasant surroundings, often with adjoining farms and spacious grounds.

The design of his buildings was split into two sections, one devoted to 'incurable' patients who were to be well occupied though removed indefinately from society, and the other to 'the cure of mental illness and neurosis'. For patients within this latter category, three types of cures were distinguished: chemical, (drugs, dietetics) mechanical and physical (including surgery) and psychic (a brand of moral psycho-therapy). Reil is said to have been a student of 'brain surgery', which points to the gradual medicalisation of methods dealing with forms of mental disturb ance.[1]

A striking feature of the period covering the Industrial Revolution was the rise of positive philosophy developed by Saint Simon and systematised by Comte, Mill, Spencer and others. 'Positivism' was seen to represent a search for facts or the systematisation of knowledge through the progress of science. The proof of the existence of something became more valuable than speculation about the 'unknowable'. 'Science' was viewed as a search for order amongst facts and the value of the experiment in which hypotheses could be tested,

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[1] Ibid P.211

began to be viewed as superior to conclusions drawn from the laws of Nature.

Darwin's theory of the evolution of biological species not only provided philosophers with an opportunity to advance a theory of progress as a continuous, if not deterministic process, but also provided medical scientists with the key to human development and hence human pathology. It was assumed that there was no difference between organic and inorganic nature and that life was "a physical phenomenon characterised by a peculiar kind of vibration in matter".[1]

If a living species could be shown to transmit biological characteristics from one generation to the next, it was possible to show that inborn characteristics in criminals, mental patients and other societal deviants were indicative of long term biological degeneracy. It was as a result of these kinds of arguments that the notion of madness as incurable biological disease or degeneracy was able to find support amongst medical scientists.

As if in support of the Darwinian thesis of biological evolution the emergence of medical bacteriology in the later nineteenth century seemed to answer the problem of disease causation. "Under these conditions it was not difficult to overlook the patient and his environment and to emphasize the cause and effect relationships between germs and disease".[2]

Emil Behring declared in 1893 that the study of infectious diseases could now be pursued unswervingly without being sidetracked by social considerations and reflections on social policy.[2] This was undoubtedly an exaggeration as considerable interest was still being shown

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1 Ibid. P.233.

2 Op. Cit. Rosen G. 1963 P.42

in matters of public health and social hygiene. In fact, the term 'medical sociology' stems from a publication of 1895. It should be remembered, however, that medicine was establishing its claim to the practical treatment of the physically and mentally 'sick' and this, to a great extent, was judged more immediately valuable to society than government policies concerning social hygiene and public health.

Perrow argues that 'moral treatments' failed to survive the nineteenth century for two reasons; firstly, because no consistent attempts were made to show that success rates were any better than in custodial assylums, and secondly, because "too many people still believed that the lunatic was subhuman, incurable or the victim of an organic degeneracy that no moral treatment could touch".[1]

By the end of the nineteenth century three distinctive approaches to questions of health and pathology had emerged and were claiming success in their own particular areas of application. Social Hygiene was concerned with the investigation and determination of how differential life styles and a predisposition towards ill-health was dependent upon social conditions. Booth and Rowntree's studies of London and York between 1890 - 1902 exemplify the kind of interest shown in the social origins of 'disease'. This was medical sociology in its earliest form, or more explicitly, social epidemiology, since the purpose of studying social conditions and the frequency and forms of illness was expressed in terms of the need to indicate aetiological factors in social pathology.

Alfred Grotjahn, one of the earliest advocates of the study of the social origins of disorders, distinguished between 'social hygiene' and 'social medicine', reserving the latter term for the practice of medical care.[2] This was perhaps one of the most significant distinctions

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1 Op.Cit. Perrow C. 1965 P.920

2 Op.Cit. Rosen G. 1963 pp.43-7

to be made at the turn of the century as it separated sociological research from medical practice - a split that was to widen as physical medicine gained ground during the twentieth century.

Somatic Medicine, as distinct from psychological medicine, generally attributed 'mental diseases' to physical causes such as brain conditions. The successes of experiments into the nature of cellular pathology as well as those in other aspects of physical and organic medicine led to the assumption that all psychic activity was a direct function of brain activity and that psychic disorder necessarily required medical treatment, often of a surgical nature. Emil Kraepelin tried to avoid the mistakes made by other doctors who were involved in studies of brain anatomy by creating a 'classification of mental illnesses'. He emphasised the importance of neurology and experimental psychology in which patients were subjected to elaborate tests as well as thorough investigation of their life histories.[1] Bleuler's term 'schizophrenia' represented a compromise between organic theories of disorder and psychogenic theories and is important in the history of psychiatry because it provided a model on which alternative studies could be based. C. G. Jung for example, was one student of Bleuler that took his point of departure from this kind of model of psychopathology.[2]

Psychoanalytic medicine represents a revolution in the theory and practice of psychiatry. Although the origins of the psychoanalytic method can be found in Freud's early exposition of 'psychoanalysis' as a means of establishing the sources of neurotic conditions, the preconditions for the rise of psychological methods of diagnosis and treatment emanate from the dual traditions of German romantic philosophy and positivism in

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1 Op.Cit. Ellenberger H.F. 1970 pp.284-5

2 Op.Cit. P.287

late nineteenth century medical thought. Freudian psychoanalysis owes a great deal to the influence of such pioneers of psychological analysis as Janet and Bergson. The central features of these approaches are contained in the notions of the 'unconscious' and plural causation.

Whereas organic theories of mental pathology have tended to rely upon nominalistic forms of causal explanation, psychoanalytic theories, by virtue of their subjective content tend to promote multifactorial explanations of causation.

The psychoanalytical view that causes are not evident prior to analysis, stresses the importance of the Unconscious in human behaviour. By assuming that the determining forces of behaviour emanate from the unconscious rather than the conscious mind, Freud and his contemporaries were reversing a view that had traditionally provided the justification behind rational treatments of the insane - that the madman was <u>responsible</u> for his actions and should therefore be punished for his misdemeanors.

Behind much of German psychoanalysis lies the Romantic notion of the Will, which was traditionally assumed to be regulated by the 'passions' and not Reason. Freud's notion of the Id is clearly a continuation of this idea, although he saw the possibility of controlling the human will through the rebuilding and reinforcement of the Ego and Superego.

If the motives behind the actions of the disordered individual are thought to derive from the unconscious, then it is possible to assume that the individual is not responsible for what he does. Furthermore, it implies that treatment is <u>necessary</u> to return the

individual to 'normality'. The 'illness' model is therefore implicit in the Freudian psychoanalytical view of madness.

It is important to remember that whereas organic medicine finds support for its theories almost entirely within the traditions of empirical science, psychoanalytic theory, to a large extent derives from metaphysical speculation and medical science. It is probably for this reason that in reference to Freud, Hughes comments that "Despite his faith in the methods of natural science; empiricism, Freud still looked to a metaphysic and a cosmology that would bring into one coherent explanation the last riddles of human existence".[1]

To match the variety of approaches to questions of mental health at the turn of the twentieth century should be added the changes in the legal and medical status of the physician. For example, the Medical Acts of 1858 and 1886 finally removed the longstanding divisions between physician, surgeon and apothecary by providing a common basis for training and registration.

Mental patients were the first for whom substantial public provisions was made from 1848 when Parliament permitted the building of country assylums for paupers. This was an unfortunate piece of legislation in many respects since it equated destitution with mental sickness which was clearly another example of class-based attitudes towards social deviance.

Perhaps in recognition of the inadequacy of the Poor Law Services, Parliament in 1867 authorised the construction of 'separate infirmaries' designed as hospitals along the lines of the existing voluntary hospitals. It is from this period that the well known 'ring' of mental hospitals around London began to emerge. Not until 1929, were the functions of

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[1] Hughes H.S. Consciousness and Society.

the Poor Law Authorities actually handed over to the modern 'local authorities'.[1]

It is a significant reflection upon nineteenth century attitudes towards mental disorder that the public hospital system was the last of a long line of hospital developments. As the old 'charity' hospitals, set up in the eighteenth century to care for the sick poor, began to become overcrowded, they restricted admission to those patients that were considered 'curable' subsequently rejecting children, pregnant women and the chronically insane, as well as those suffering from infectious and venereal diseases. It was as a result of this selection procedure that the residual population of the chronically sick were placed in the 'infirmaries'. Given that these public hospitals had no choice but to receive into care persons considered to be rejects from other hospitals as well as from society, it is not surprising that they began to be viewed as custodial assylums instead of centres for the sympathetic care of the chronically sick.

The lumping together of the mentally disordered along with 'societal rejects' such as orphans and mothers of illegitimate children as well as the physically disabled and chronically infirm exemplifies the practice of equating mental disorder with illness and forms of social deviance.

McKeown has argued that, since Kepler, medical thought has been dominated by an 'engineering approach' to matters of health, based on an understanding of the structure and function of the body and the disease processes which affect it. This, he continues, has "been largely responsible for the significance attached to the work of the acute hospitals and for the relative neglect of psychiatric, geriatric and some other forms of care...".[2] The division between 'favoured'

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1 McKeown T. A Sociological Approach to the History of Medicine. Medical History, 1970 pp.342-349

2 Ibid P.343 (my italics)

and 'depressed' areas in medicine clearly reflects this early practice of selection and rejection according to degrees of medically-defined chronicity.

It was through the application of these varying ideas and approaches to medicine and health policy that the twentieth century was to see, on the one hand, the development of institutional psychiatry as a public service, and the growth of private psychiatric practice, on the other.

Central to the development of public health policy in Britain, was the growing emphasis placed upon the notion of 'social consciousness' with the concomitant de-emphasis upon the ideology of individualism.[1] The sociological interest in the family as the unit of study in questions of mental disturbance, coupled with the development of 'preventive medicine' reflected the growing interest in the social aspects of health and pathology in the period prior to the second world war.

From the point of view of private medicine it has been suggested that psychodynamic approaches to mental disorder introduced a ray of hope into the field of psychiatric intervention at a time when mental hospitals were being criticised for their seeming inability to find practical as well as humane methods of treating the acutely disordered. Rapoport claims that these psychodynamic approaches "brought into psychiatry a therapeutic method that was more than simply naturalistic classification, and allowed more than simply sporadic, unexplained, empirical success".[2]

It was thus in an atmosphere of change and experiment that the early formulations of 'milieu therapy' and 'therapeutic community' were

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1 Op.Cit. Rosen G. 1963 P.47

2 Rapoport R.N. et al. Community as Doctor: New perspectives on a Therapeutic Community. Tavistock 1960 P.9.

established prior to 1939. Paradoxically, it was largely as a result of the social fragmentation brought about by the second world war that significant changes in the use of the institutional psychiatric milieu were able to take place. Once again, as the historical process shows, changes in the moral and social climate of Europe led to new definitions of madness and notions of treatment. It is to these questions that we now turn.

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CHAPTER 5

THE ORIGINS OF THE CONCEPT OF THE THERAPEUTIC COMMUNITY

If the nineteenth century can be said to have witnessed the systematization of approaches to mental disorders, then the present century must surely be said to have witnessed the cross-fertilisation of the ideas contained within these various approaches. The use of the hospital 'milieu' as a therapeutic agent exemplifies the contemporary medico-social attitude towards the treatment of mental disorders. Similarly, medical acceptance of psychotherapy as a transactional process through which the patient is encouraged to evaluate and reorient his life experiences, points to the influence that psychoanalysis and the social sciences have had upon definitions of sanity and madness.

Perhaps the major change in thinking about the nature of mental disorder is contained in the notion of '<u>situational</u>' pathology. This implies that the terms 'madness' and 'insanity' are not concerned with specific characteristics of <u>individual</u> pathology, but have to do with the complex interrelationship between the individual and his social environment.

When one considers that the discipline known as 'psychiatry' developed from within the medical-scientific traditions of the late nineteenth century which were then largely concerned with the classification of organic mental 'diseases', it seems remarkable that the same discipline has since come to accept the role played by social factors in the aetiology of mental disorders.

There are many reasons behind the changes in psychiatric theory, the most notable being the reciprocal exchange of ideas and concepts between psychoanalysts and sociologists during the early part of the twentieth century. It is widely assumed that 'social psychiatry' emerged as a result of the influence that sociological theory exerted over psychiatrists prior to the 1930's. Although this is undoubtedly true, it tends to obscure the even greater influence that psychoanalytic concepts first had on social-scientific theories of behaviour. "Until sociologists had explored the theories and tested the analytic tools of psychiatrists' writes Eliot "they could hardly be expected to contribute to psychiatric theory either positively or by adverse criticism. During the period... 1915-1940, the preponderant currents were from psychoanalysis to the social sciences rather than from sociology to psychiatry".[1]

In his later writings, Freud recognised the importance of the socio-cultural milieu in the psychopathology of the individual. His 'anthropological' works (Totem and Taboo, The Psychopathology of Everyday Life) bear witness to his growing awareness that the neuroses, although manifestations of repressed libidinal drives within the individual, were also manifestations of societal repressions, and that the individual was, therefore, subject to forms of cultural repression during the process of 'socialization'.

The neo-Freudian emphasis upon cultural and situational factors in the genesis of neurotic and psychotic conditions was not as dramatic a break from Freud's thinking as is often imagined. Although Jung and

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1 Eliot T.D. Interactions of Psychiatric and Social Theory Prior to 1940 in A.M. Rose (ed) Mental Health and Mental Disorder. Routledge & Kegan Paul 1956 pp.20-21

Adler disagreed with Freud over the question of the libido being the expression of 'sexual instinct', they nevertheless accepted in principle that early childhood experiences provided the background to adult psychopathology.

Having accepted that mental disorders originated from disturbed psycho-social environments as distinct from the organic pathology of the human organism, it became possible for psychoanalysts and social scientists to fruitfully exchange information and ideas concerning the role of social factors in human behaviour.

Groves studies of 'normal' and group behaviour in 1916 were based upon psychoanalytic concepts and theories, and a paper of the following year openly recognised the significance of Freudian and Neo-Freudian theories and insights for the interpretation of general social behaviour.[1] American sociology could well be said to have originated during this period.

In 1918, W. I. Thomas and Florian Znaniecki "introduced the social situational interpretation of motivation as contrasted with the instinctual or internal interpretation".[2] In their study of the Polish peasant, they recognised that the strains placed by social change and migration upon personal integration could be said to give rise to mental disorder and delinquency.

From 1919, the American Sociological Society showed increasing interest in the sociological implications of psychiatry with the result that terms such as 'psychiatric sociology' and 'socio-analysis' emerged as theoretical counterparts to 'social psychiatry' which referred to applied techniques in mental hygiene and psychiatric social work.[3]

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1 Ibid pp.22-3

2 Ibid P.25

3 Ibid P.26

Elton Mayo's social psychology of industry dates from about 1923 in which he recognised that both 'normal' and 'psychopathic' personality conditions contained features of repression and compensation and that these were both causes and effects of industrial disorganisation. By the 1930's, he had assumed as given, that social causes produce or accentuate personal pathology.[1]

Under the influence of W. I. Thomas, the American Sociological Society during the early 1930's introduced a programme of studies on the question of the relationship between sociology and psychiatry. Papers were presented by such personalities as Harry Stack Sullivan, Adolph Meyer and Herbert Blumer all of whom sought to increase the potentialities of cross-disciplinary studies in social-psychiatric theory.

Despite the apparent ease with which the social sciences and psychoanalysis came together it should not be forgotten that another major school of thought apart from psychoanalysis was responsible for the transformation of the view of man from a static organism to a 'dynamic being in a total environment'. Breaking away from the Kraepelinian tradition of classifying forms of mental diseases by type, and away from the psychoanalytic practice of viewing behaviour as a manifestation of hidden unconscious motives, the 'psychobiological school' of which Adolph Meyer and William A. White were representatives, viewed man and his experiential environment, holistically, that is, as a dynamic interrelationship between consciousness and the physical-social world. Thus, comments Kirson-Weinberg, "In attempting to understand the

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[1] Ibid pp.30-1

disordered person as a dynamic social being instead of as a pathological organism, or as an isolated individual within the clinic, the psychiatrist had to acknowledge the influence of the social relationships upon the patients disordered conditions".[1]

It is interesting to note that Bentley maintained in 1934, that a comparison of psychiatric theory between his generation and that of his immediate forebears would have shown the increased emphasis upon the "socialisation of the subject, Then the patient was an afflicted organism; now he is a disturbed, distorted and unadjusted member of a family and a community; in this sense he is a disordered person".[1]

Numerous important studies of the interaction between man and the environment were undertaken during the 1930's. In the traditions established by Cooley and G. H. Mead, 'role' theory emerged to become a central element in the theories of Robert Merton and Talcot Parsons. The term 'interpersonal relations' seems to have found support during this period. It was perhaps Harry Stack Sullivan who was most instrumental in emphasising the interpersonal and social as against the instictual-sexual in concepts of the self. He claimed that "Psychiatry is the study of processes that involve or go on between people", a view which was to underpin his conception of milieu therapy for schizophrenic patients.

Before going on to discuss the direct influences that these theories, approaches and innovations had upon the origin of the concept of the therapeutic community, it is worth taking the opportunity to clarify some of the major issues referred to so far.

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[1] Weinberg S. Kirson. Social Interaction as an Orientation to Mental Disorders Among the Behavioural Sciences Prior to 1950. In the Sociology of Mental Disorders. Staples Press 1967 pp.8-15

Firstly, the notion of man as a social animal began to replace the older mechanistic model of man as a biological organism. This reflected a growing awareness that certain disorders could not be explained adequately on the basis of biological and instinctual factors, and gave recognition to the importance of early socialization experiences in the development of the human personality.

Secondly, the shift from a static to a dynamic view of personality made psychoanalysts, psychologists and psychiatric social workers more aware of the relevance of social processes in psychopathology. A major consequence of this development was the recognition that the process of understanding the mind of the patient originated in the transaction between patient and analyst; in other words, the therapeutic situation was an interactional phenomenon.

Finally, out of this fundamental shift in direction, emerged the concept of 'communication' between patient and therapist in which even the fragmented experience of the 'psychotic' was considered worthy of attention. The psychoanalytic transaction, which paved the way toward the later psychotherapies, was, therefore, instrumental in the 'humanising' of psychiatry in the twentieth century, and it is through its widening influence that the concept of a psychotherapeutic 'milieu' was first able to gain acceptance amongst institutionally-based psychiatrists.

The origins of the 'therapeutic community' are generally thought to have arisen out of the changing currents of psychiatric and sociological thought in the period prior to the second world war. It seems clear that the growing emphasis upon hope rather than neglect was encouraged by the developing interest shown by the medical profession in the social sciences and dynamic psychologies.

The emergence of social psychology and social anthropology during the 1920's and 30's led to experiments being carried out in hospitals in which social psychological hypotheses were tested.

In 1931, Harry Stack Sullivan wrote that "some ten years rather close contact with sufferers of schizophrenic disorders culminated in the firm conviction that not sick individuals but complex, peculiarly characterised situations were the subject matter of research and therapy".[1] The implication of this statement was, of course, that there was another significant factor involved in the therapeutic process apart from the patient-therapist relationship and that was the social milieu in which this relationship took place, and of which it was a part. Sullivan's subsequent studies led him to hypothesise that the 'milieu' was one of the major factors contributing to patient change.

An early study by Robert Faris in 1932, of cultural factors in the ecological distribution of psychosis, led him to the conclusion that where social contacts were 'adequate' and persons were neither sheltered from, nor ostracised by the prevailing culture, schizophrenia was rare. However, where it did arise, Faris argued that it should be combated through the therapeutic restoration of group acceptance and participation.[2] In his later association with H. Warren Dunham, Faris reiterated his thesis by showing that differential levels of social stratification could account for a greater proportion of schizophrenic disorders in slum areas, compared with a larger proportion of manic-depressive conditions from the higher social levels than the lower levels.

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1 Sullivan H.S. Socio-Psychiatric Research - it's implication for the schizophrenic problem and for mental hygiene. Amer. Journ. Psychiat. 1931, 87, pp.977-991.

2 Faris R. Insanity Distribution by Local Areas. Proceedings of the American Statistical Association XXV11 March 1932, pp.53-7. Cited in A.M. Rose (1956) Op.Cit. P.35

The data for these studies were drawn from statistics relating to admissions to four State Hospitals in the Chicago area during the period, 1922-34.[1]

Ecological studies of the distribution and frequency of mental disorder, delinquency and other aspects of social deviance, not only contributed towards the development of epidemiological study in sociology but also gave rise to a number of supporting questions of a controversial nature. Linking the incidence of certain 'types' of mental disorder to varying social conditions within a given society and culture, allowed for the following interpretations; that (i) Mental disorder was culturally defined and therefore cultural definitions and sanctions rather than forms of individual pathology should become the objects of study. This also provided a justification for viewing society as a potentially 'sick organism', If, (ii) societal pathology could be shown to exist in, or derive from areas of 'functional disorganisation', then changes in those areas should, theoretically, restore social equilibrium. The basis of the belief in society as a 'social system' was to have a resounding effect upon theories of institutional functioning and the maintenance of social order.

Although early criticisms of these theories tended to assume that an 'organic fallacy' was being committed, the real issue was, in the meantime, being obscured. Read Bain, for example, pointed out that the opportunities for the realisation of societally prescribed goals were differentially distributed throughout society according to such factors as education, sex, family, class ('economics') and morals.[2]

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1 Faris, Dunham H.W. Mental Disorders in Urban Areas. Univ. of Chicago Press 1939.

2 Bain R. 'Our Schizoid Culture'. Sociology and Social Research X1X 1935 pp.266-76.

The incidence of mental pathology, traceable at an individual level, was assumed to derive from aspects of cultural stress and societal disorganisation.

Although at this time the exact nature of the relationship between individual breakdown and social disorganisation was open to question[1] its general acceptance as a theory was already established. In October 1938, Robert Merton argued, in a now famous paper,[2] that certain phases of social structure generate the circumstances in which deviation from societally prescribed behaviour is a normal, not a pathological response. He further asserted that sociological theory had traditionally attributed the malfunctioning of social structure to man's 'imperious biological drives' which were thought to be inadequately restrained by social control. Non-conformity had thus been assumed to be rooted in a natural process.

Merton's 'paradigm' which outlined five 'pattern variables', or modes of adjustment to societal situations, sought to explain how certain groups in society were differentially disposed towards the use of 'institutional means' in the attainment of culturally prescribed goals. The 'anomic' situation of the 'retreatist' was thought to derive from an individual's rejection of both the means and the goals existent in his culture, with the result that he 'drops out' only to experience frustration and further conflict resulting in depression and resignation to a state of total defeat.

What is greatly significant about this paradigm is Merton's implicit advancement of a voluntaristic conception of deviation. He was arguing that men do not break rules through blind biological drives

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1 Blumer H. Social Disorganisation and Individual Disorganisation. American Journal of Sociology SL11 1937 (May) pp.871-7

2 Merton R.K. Social Structure and Anomie. American Sociological Review. October 1938.

but instead, derive their goals knowingly from the basic values of the culture. In other words the individual who deviates from culturally prescribed norms does so by volition and hence is responsible for his actions.

'Social Structure and Anomie' provided sociology with one of the vital links between theories of social structure and theories of deviance. Combined with early formulations of 'social systems theory', Merton's voluntaristic role theory helped to make possible both the study of the mental institution as a social system as well as the study of institutional psychopathology as an interactional phenomenon. Take, for example, Rowland's 1939 definition of the hospital as a social system;

"As a community the mental hospital is a social system with a definite structure and many complex social processes. It is a community of interacting individuals who are participating in a living drama.... the mental hospital itself should become the object of further specific analysis. It is an excellent laboratory for research into social relationships".[1]

In his lectures of 1938-40, Sullivan is reported to have first used the term 'therapeutic community' to describe the nature of an experimental psychiatric milieu in which the intrinsic features of the living situation were seen to play a major role in patient progress.[2]

It seems that once the idea that an institutional milieu could be shown to contribute towards patient progress, other psychiatrists both in Europe and America saw fit to experiment with similar ideas. The

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1 Rowland H. 'Friendship in a State Mental Hospital', Psychiatry 2, 1939, pp.363-373.

2 Sullivan H.S. Conceptions of Modern Psychiatry. Wash. D.C. W.A. White Psychiatric Foundation 1940.

early 1940's thus witnessed the excitement felt by growing numbers of medical personnel over the development of programmes of treatment utilising the social milieu of the psychiatric hospital.

In America, the 'Topeka Programme' sought to link interpersonal relations in hospital to methods of treatment,[1] while Myerson was evolving a method of treating and rehabilitating 'chronic schizophrenics' by means of a concept known as 'total push' which was characterised by the consistent use of the total resources of the environment in reactivating the patients.[2] (Even the advocation of punishments and force in methods of reactivating chronic patients was considered acceptable within the general theory of 'total push'[3] - a notion remarkably similar in ethos to Rush's use of punitive methods in the 'moral treatment' of the insane during the early nineteenth century).[4]

Bettleheim's work with disturbed children in Chicago led him to the conclusion that individual psychoanalysis was an unnecessary mode of treatment and that 'psychotherapy' was the relevant term to describe the use of the environment or the 'social milieu' in the treatment process.[5]

In England, the major changes in therapeutic direction occurred

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1 Menninger K. & W.C., Man Against Himself and Functions of the Psychiatric Hospital. Bull of Menn. Clinic 6, 1942 pp.109-140.

2 Myerson A. Theory & Principles of the Total Push Method in the Treatment of Chronic Schizophrenia. American Journ. of Psychology, 95, 1939 pp.1147-1204.

3 Tillotson K.J. The Practice of the Total Push Method in the Treatment of Chronic Schizophrenia. American Journ. of Psychology 95, 1939, pp.1205-1213.

4 See reference to Benjamin Rush. Chapter 1, Part 2, pp.

5 Quoted in Conran M.B., The Family as a Model in the Application of Psychoanalysis to the Care and Treatment of Young Male Schizophrenics. Unpublished M.D. Thesis Univ. of London Jan. 1971, P.17

during and immediately after the second world war. A small collection of psychiatrists known as the 'Northfield Group' proved that it was possible to treat shell-shock and psychoneurotic conditions in small psychotherapeutic groups during which special attention was paid to the involvement of these patients in the organisation and running of their wards.[1]

The culmination of the Group's work can best be summarised in the now celebrated statement by T. F. Main, concerning the changing nature of the psychiatric milieu. He referred to "an attempt to use a hospital not as an organisation run by doctors in the interest of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life.... Ideally it has been conceived as a therapeutic setting with a spontaneous and emotionally structured (rather than medically dictated) organisation in which all staff and patients engage".[2]

Main envisaged the 'therapeutic institution' as embodying three important new features: (i) active denial of patient dependence on the hospital, (ii) an emphasis upon the curative rather than the damaging aspects of the psychiatric milieu, and (iii) the use of group psychotherapy as an integral part of a total 'milieu' treatment programme.

During the late 1940's an experiment in 'social therapy' was carried out at Belmont Hospital in Surrey in which the treatment of 'psychopathic' personalities by means of the full utilisation of a special 'milieu' was undertaken with some considerable success.

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1 Bion W.R., Rickman J. Foulks S.H., Intagroup Tensions in Therapy. Lancet 1940 ii P.678. Introduction to Group Analytic Psychotherapy. Heinemann London 1948.

2 Main T.F. 'The Hospital as a Therapeutic Institution', Bull of Menn Clinic, 10, 1946 pp.66-70.

The 'Social Rehabilitation Unit' was managed by a then little known psychiatrist by the name of Maxwell Jones, who today is regarded as the pioneer of the contemporary concept of the 'therapeutic community'. Jones' main therapeutic work was carried out in meetings with patients during the course of which everything that happened in their daily lives was examined. It was through these early attempts to establish communication between patients and staff that these new forms of psychiatric milieu came to be known as 'living-learning' situations.

Despite the initial enthusiasm over the re-discovery of the therapeutic potential of the social-psychiatric milieu, it should be remembered that at the end of the 1940's institutional psychiatry still relied upon biophysical explanations of mental disorder, and psychiatric institutions were still manifestly custodial in both appearance and practice. Ten years later, however, considerable changes had been effected throughout a large area of institutional psychiatry. What then were the key factors responsible for these innovations?

Since no single factor could be said to have causal priority it can be argued that the significance of each factor derives in part from its contingent relationship to all the others. The conceptual origins of 'milieu therapy' and 'therapeutic community' are, therefore, multi-dimensional. In order to bring some degree of taxonomic clarity to this diverse area of influential factors, five groups of variables can be said to contain the major components of change. These are:

1. Psychopharmacological research, Neurosurgery and Electroplexy.
2. The 'Open Door' Policy in hospitals.
3. Instigation and development of Occupational and Work therapies.
4. Changes in status of mental patients after 1959. Voluntary admission.
5. Influence of critical studies of mental hospital practice by social scientists.

1. Psychopharmacological Research, Neurosurgery & Electroplexy.

The most positive reactions to research into psychopharmacology were those associated with the use of insulin in the relief of schizophrenic symptoms. It was assumed that the therapeutic effects of insulin shock treatment derived from the chemical action of the drug. It became clear to those studying the treatment procedure, however, that the dramatic recoveries of some patients owed more to the open communication, cooperation and teamwork of the doctors and nurses in administering the potentially dangerous drug than to the physical property of the drug itself.[1,2] As a result of these findings attention was directed to the study of group communications and processes with an emphasis upon the positive nature of staff-patient relationships.

'Success' in the treatment of schizophrenia gave rise to optimism amongst hospital staff concerning further attempts to utilise experimental treatment procedures. It was generally felt that limited success in methods of reactivating chronic patients was better than merely observing and restraining them. This attitude undoubtedly helped to foster a sense of purpose amongst hospital personnel, resulting in the awareness that change was not only possible, but desirable as well.

Describing the usage of chemotherapy and electroplexy during the 1950's, Crowcroft argues that it was not the drugs, or the equipment that produced therapeutic results, but simply that "patients improved because they were selected for it".[3] He explains that because patients were formed into small groups for 'treatment' they received better

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1 Bourne H. The Insulin Myth; Lancet 1953 ii P.964.

2 Ackner B. et al, Insulin Treatment of Schizophrenia: A Controlled Study. Lancet 1957, i P.607.

nursing care than under normal institutional conditions, and they lived in an atmosphere of optimism due to the faith in the treatments used. As particular treatments were discredited, the value of the social groups was noted with the result that they came to be seen as primary goals in the facilitation of further treatment.

The emphasis during the 1939-45 war upon research into the origins and treatments of diseases led to advances being made in general drug usage. Through the use of drugs such as suplhonamides and penicillin many forms of acute disease were eradicated thus leaving the chronic open to medical and public view. Since mental hospitals were still the "biggest repositories of the chronically ill" they naturally could not escape critical scrutiny. As pressure was exerted by the critics, greater concern began to be shown in some hospitals for the plight of chronically disordered patients. This concern may well have contributed towards post-war interest in experimentation with physical methods of treatment.

With the same enthusiasm that greeted the introduction of insulin shock therapy, the use of electro-convulsive therapy (E.C.T.) found support amongst doctors after it was optimistically shown that the treatment resulted in a 70% reduction in the period of time that a depressed patient stayed in hospital. Characteristically, however, it was soon discovered that these kinds of treatment "did not greatly reduce the complement of patients <u>whose illness became chronic</u> since deep insulin treatment (as well as electro-convulsive therapy) worked best on those patients likely to recover spontaneously, while depressive illnesses end of their own accord whether they are treated or not....".[1]

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[1] Hays P. New Methods in Psychiatric Hospitals in New Horizons in Psychiatry. Pelican 19 P. (my italics).

The lack of positive success with these methods did not mean that the task of treating chronicity was abandoned. Experience gained from successes in private psychiatric practice as well as from the new hospital in-patient treatments, pointed to the possibility of restoring the chronically disturbed to health. The very fact that a distinction was made between 'acute' disorder and chronicity, which implied a qualitative difference between the 'acutely disturbed' and the 'insane' meant that people did not just 'go mad' because of some pre-ordained organic pathology, but could be allowed to become chronically insane as a result of neglect and misunderstanding. The emphasis was thus shifted towards early therapeutic intervention and attempts at re-stimulation of longer-stay patients.

Major changes in the handling of institutionalised mental patients took place following the introduction of tranquilisers and anti-depressants during the 1950's. These new drugs claimed to be as successful in the treatment of psychotic disorder as in the treatment of neurotic and personality disorders. The phenothiazine-derivative tranquilisers such as chlorpromazine, (largactil) were thought to have special advantages in the treatment of schizophrenic symptomatology in that the "pathologically elated mood and overactivity of most manic patients could be moderated".[1]

Another group of drugs known as the Monoamine Oxidase Inhibitors were thought to relieve depression and to control hysterical conditions. Young people, it was found, responded well to these kinds of anti-depressants which added weight to the belief that reactive disorders could be dealt with relatively quickly - avoiding the possibility of institution-alisation and further emphasising the need for rehabilitation back into the wider community.

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[1] Op.Cit. Crowcroft A. 1967 P.136

The introduction of tranquilisers may also have shifted the balance away from the more mechanical methods of treating psychotic disorders, exemplified in the neuro-surgical practice of prefrontal leucotomy, in favour of the containment of severe symptoms by means of drugs. Once it had been shown that the incidence of chronicity could be meaningfully reduced without recourse either to neuro-surgery or electroplexy but through the 'therapeutic' prescription of drugs, previous notions of custody, incurable insanity and permanent exile from the outside world, began to be viewed as old-fashioned and even 'un-therapeutic'.

The concepts of 'total push', 'reactivation' and 'milieu therapy' derive from this newly-found confidence in methods of treating acute and chronic patients. If patients could be 'reactivated' it followed that they might be 'cured'. Improvement or cure implied a sense of hope as well as purpose and this further implied movement in the numbers constituting the traditionally static mental hospital populations. Rehabilitation thus came into its own "after the medical measures that were possible had done as much as they were capable of by way of restoring the patient to contact with reality, stabilising his emotional equilibrium and so on".[1]

Advances in psychopharmacology could be said to have provided the breakthrough that was needed to ensure the stability of the milieu in which the patient was to be treated. Despite the fact that he was still the passive recipient of treatment rather than an active participant in a 'therapeutic process', the patient was nevertheless, through the use of drugs, being made ready for a new kind of treatment experience, -

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[1] Op. Cit. Rapoport R.N. 1960 P.17.

psychotherapy. This innovation in meaningful communication with the patient has developed slowly in institutional psychiatric settings although its importance to the understanding of the therapeutic potential of the psychiatric milieu cannot be underestimated.

2. The 'Open Door' Policy in Psychiatric Hospitals

In 1953, the World Health Organisation published a report on the findings of its Expert Committee on Mental Health. The recommendations were thorough and far-sighted, coming at a time when even the most basic changes in hospital management and methods of treatment had yet to be undertaken. Describing how modifications could be made to hospital structure and goals, the Report suggested that "Too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and a prison. Whereas, in fact, the role they have to play is different from either; it is that of a therapeutic community".[1]

Establishing such a community, however, requires certain basic changes in the relationship between the hospital and the wider community, as well as in staff-patient interaction within hospitals themselves. Rehabilitation procedures, for example, are explicitly encouraged in the following paragraph taken from the section on 'treatment' in the Report: "If the psychiatric hospital is to be a therapeutic community it must gradually impose upon recovering patients the responsibility which citizenship of the (wider) community implies".[2]

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1 W.H.O. Technical Report Series No.73. Expert Committee on Mental Health, Third Report. P.18, 1953.

2 Ibid P.20.

To make the transition from hospital to the outside world easier, it was suggested that hospital wards should be made 'more like home' (P.22) and that prior to a patient's departure, outside visitors should be encouraged in order to be certain that "life within the hospital should, as far as possible, be modelled on life within the community in which it is set". (P.19)

In theory, these ideas sound highly tenable, but it should not be forgotten that these proposals were being advanced in 1953, when most psychiatric hospitals subscribed to the belief that patients should be kept locked in for 'their safety' as well as for the 'safety of society'. ("The locked door not only keeps the patient in, it keeps the public out").[1] It therefore came as a surprise when courageous innovators such as Dr. G. M. Bell of Dingleton Hospital, Melrose, succeeded in opening all ward doors on a permanent basis as early as 1949.[2] D. H. Clark notes that such an advance was not made without difficulty: "Dr. Bell spent many hours with the local police, the bailies, the provost, the lawyers and the citizens, cajoling and explaining".[2]

Custodial incarceration from the time of the birth of the assylum, has afforded society 'protection' against irrationality in the form of uncontrollable or anti-social behaviour. Despite the liberalisation of attitudes towards mental disorder that took place during the first half of the twentieth century, it was still generally felt by 1950 that the insane needed 'locking up for their own good'. The possibility that all hospitals might open their locked ward doors was, therefore, received with considerable apprehension.

By 1954, a few hospitals had succeeded in opening all ward doors with the result that extensive discussion of the issue was promoted

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1 Ibid pp.18-19.

2 Clark D. H. Administrative Therapy: The Role of the Doctor in the Therapeutic Community. Tavistock 1964, P.19

throughout British psychiatry. The fears expressed prior to the unlocking experiments were shown to be unfounded; there were no mass escapes or unusually dramatic events and no breakdown in discipline. To the contrary, violence was seen to decline, 'escaping' was no longer regarded as a good reason for extra custodial protection and punitive sanction, and relationships between staff and patients were seen to improve. Attention began to be directed towards 'therapy' rather than 'custody' as it was felt that there was a diminishing likelihood of escape or violence.

Hays comments: "Chronic psychotics lost interest in escaping, stopped talking about their delusions and suffered less from hallucinations. What had passed for psychotic behaviour for a hundred years, was found really to be the result, not purely of mental illness, but of mental illness in a setting of severe restriction of the social freedom and liberty of the person..."[1]

Madness was beginning to be viewed as a temporary state and not as an irreversible psycho-biological condition.

The opening of locked doors may have been considerably aided by the introduction of tranquilising drugs in as far as that they helped to stabilise the more destructive forces behind some patients' disturbances. It is nevertheless a mistaken belief that the opening of the wards was brought about by the coincident introduction of tranquilisers, since discharge figures show a rise that antedotes equivalent success rates deriving from drug use.[2]

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1 Hays P. Op.Cit P.

2 Hays P. Op.Cit P.

D. H. Clark pointed out an interesting response on the part of some patients to the unlocking of the female long-stay wards at Fulborne Hospital in 1951. He notes that nothing problematic occurred whatsoever "though several patients commented unfavourably that now the other people could get in".[1]

By 1963, 80% of English psychiatric hospitals had open ward doors and today 'locked wards' are a rare occurrence. The overall benefits of the unlocking experiments are most noticeable in the contribution that they made to communication and freedom of movement within the hospital, and in particular to the way in which patients felt themselves free to be able to choose whether to receive and co-operate in treatment. Without a recognition of this elementary human right the so-called 'democratic-permissive' ethos of the psychotherapeutic community would not have been able to emerge and institutional psychiatry might well have had to wait even longer to discard its custodial image.

3. The Development of the Occupational and Work Therapies

The changing definition of 'madness' from a static to a dynamic or processual phenomenon allowed for the interpretation that if psychiatric disturbance could manifest itself in the individual without specifiable causes, then it followed that it might be possible, given the relevant treatment or encouragement, to help the patient to work through his difficulties and perhaps rehabilitate him back into the wider community. Once it had been shown that 'mental illness' was not an irreversible condition, interest in doing something rather than nothing became the rule rather than the exception.

The work and occupational therapies emerged out of the growing awareness that something should be done to help patients to keep in

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[1] D. H. Clark Op Cit P.21.

contact with the everyday living and working experience of the outside world, thus helping to avoid regression into chronicity.

Despite the paternalistic sympathies underlying the introduction of these methods of patient reactivation, they nevertheless contributed considerably, during the 1950's and 60's to the swing towards the formation of 'therapeutic teams' of doctors, nurses and non-medical personnel, who made it their jobs to find more effective ways of encouraging patients to help themselves.

Work therapy was originally inspired by Dr. Hermann Simon of Gutersloh Hospital. His work led to a number of Dutch hospitals taking an active interest in farming, domestic and light industrial tasks. Describing these innovations, Clark comments that although an authoritarian atmosphere still existed, the major achievements were to be found in the increased morale of the patients. For example, "there are no wards full of idle, deteriorated, neglected, hopeless persons; there are few incontinent patients; no patients half naked and in tettered clothing; very few persons showing catatonic immobility and flexibilitos cerea, and few restraint devices".[1]

In 1933, the English Board of Control arranged for psychiatrists to visit Holland and learn about the new methods being used in mental hospitals. As a result, 'occupational therapy' experiments were carried out at a number of hospitals throughout England.

The introduction of the role of the 'occupational therapist' although in evidence after the establishment of industrial workshops during the later 1940's and early 50's, ironically, owes most to the recognition of the need to retrain patients that had undergone neurosurgery.

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[1] Op.Cit. Clark D.H. 1964 P.16.

It was found that post-operative rehabilitation required careful planning and that occupational therapy seemed most suited to the process of retraining patients for the simpler work tasks. It followed that if success could be made with patients that had undergone pre-frontal leucotomy, "It was only a short step to training those whose brains were intact"[1] - a view that probably accounts for the expansion of occupational therapy facilities throughout British psychiatric hospitals.

The teamwork spirit that seems to pervade most accounts of these experiments can also be found in accounts of 'total push' programme to which we shall refer shortly. The overall contribution that these examples of teamwork made to later milieu therapy projects can be guaged from the consistant emphasis that was laid upon stimulation of patients rather than neglect, joint consultation and delegation of responsibility, social rehabilitation rather than institutional isolation, and significantly, sexual integration during 'working hours' - considered by many administrators at the time to have been unmanageable. It was found that not only did occupational therapists find it easier to manage mixed groups but that (not surprisingly) "once patients began to mingle, it began to look like a normal community".[2]

4. Changes in the Status of the Mental Patient: Voluntary Admission

It is widely held that the Mental Treatment Act of 1930 and the Mental Health Act of 1959, were major turning points in the history of public attitudes to mental disorder. Their emphasis upon 'informal hospital admission' giving rise to a voluntary in-patient status has not only helped to reduce compulsory admissions to hospital, but has further

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1 & 2 Op.Cit. Hays P. New Horizons in Psychiatry.

contributed to the post-war de-emphasis upon custodialism.

These Acts, however, are not the first examples of government legislation that have attempted to improve the lot of the mental patient. The Lunacy Acts of 1845 and 1890 which were passed as a result of public concern over the risk of improper detention in asylums, paradoxically had a detrimental effect upon the statuses of mental patients and the procedures of referral and discharge. This was probably due to the fact that the spirit of reformism that was so characteristic of the nineteenth century, also gave rise to the belief that too much liberty could result in madness because it permitted greater freedom of thought. In the Act of 1845 therefore, Local Authorities were on the one hand encouraged to build more large asylums while, on the other, they were directed to make certification so cumbersome a procedure that only the severely disturbed were to be committed.

The later Act of 1890 not surprisingly, went on to specify that asylums could only receive the 'certified', that is those patients who were regarded as 'very mad'. This action, no doubt, reflected the increase in the numbers of patients defined as 'certifiable' during the period 1845-90. The combined effect of these two Acts was to facilitate the growth of asylums for the chronically ill. In 1850, for example, twenty four asylums managed 300 patients, whereas by 1900 seventy-seven asylums managed an average of 1000 patients each.

One of the innovations of the Mental Treatment Act of 1930 was the provision made in it for <u>voluntary</u> admission and voluntary discharge : "Any person who is desirous of voluntarily submitting himself to treatment for mental illness.... may without a reception order be received as a voluntary patient in an institution within the meaning

of this Act, or in any hospital, nursing home or place approved for the purposes of this section by the Board of Control..."[1] and, ... "may leave the institution, hospital, home or place, upon giving to the person in charge seventy-two hours notice in writing of his intention to do so..."[2]

The introduction of a 'voluntary patient' status was especially significant because it implied a recognition on the part of the medical profession that mental disorder was reversible and that its origins could be traced as readily in the psychosocial environments of the patient as in the psychobiological organism.

The 1959 Mental Health Act went as far as to define 'mental illness' as "arrested or incomplete development of mind, psychopathic disorder and <u>any other disorder or disability of mind</u>"[3] which, in effect, admitted to uncertainty about the nature and range of disorders which come under the collective heading of 'illness'.

Where the 1959 Act enlarged and improved upon the 1930 Act was in its recommendations for a liberalisation of the methods and facilities used in the care of the mentally disordered.

It stipulated, for example, that:

1. As much treatment as possible, both in hospital and <u>outside</u> should be given on an informal and voluntary basis.
2. The emphasis in mental cases should be shifted so far as possible, from institutional care, to <u>care within the community</u>.[4]

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1 Mental Treatment Act 1930 Section 1, Para. 1 HMSO.

2 Ibid Section 1 Para. 5.

3 Mental Health Act 1959 Section 4, Para.1, HMSO (my italics)

4 A Guide to the Mental Health Act Op.Cit P.1.

As in the cases of the earlier Lunacy Acts, procedures for certification, that is for compulsory admission to hospital, were made more cumbersome by virtue of the fact that the emphasis had been shifted in favour of keeping people 'out in the community', where possible. By drawing attention to the possibility of providing external care through community health centres, day hospitals and after-care hostels, the general public were asked to accept that mental disorder was as much a product of distorted social interaction as it was a manifestation of some unique individual pathology.

Commenting upon changes in attitude towards mental disorder during the 1950's and 60's, May shows that where deviant behaviour was used as an indicator of clinical illness, those responsible for removal were "in fact, arranging for the discharge of the patient from the community". In other words, responsibility for the patient ended when he or she was admitted to hospital.[1]

The introduction of community care facilities was, therefore, an attempt to reverse the trend through which individuals were labled and removed from the 'normal' community for 're-processing'. The provisions laid down in the Mental Health Act of 1959 relating to voluntary admission to hospital and for the enlargement of community mental health facilities clearly helped to make such changes possible. Subsequent reductions in the size of mental hospital populations, coupled with the expansion of social work facilities in the community bear witness to the resourcefulness of the 1959 Act.

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[1] May A. R. Principles Underlying Community Care, in Psychiatric Hospital Care Ed H. Freeman, Balliere Tindall & Cassall 1965 P.114 (orig. italics).

5. Social Scientific Studies of the Mental Hospital

We have already seen how the cross-fertilisation of social-scientific and psychiatric ideas culminated in some interesting experiments in the organisation of 'milieu therapy'.

It should be emphasised that these same currents of thought influenced hospital administrators and psychiatrists interested in the social-structural aspects of hospital practice.

Some of the earliest attempts to understand the effects of prolonged incarceration in an asylum were those of Devereux in the mid 1940's. In a paper published in 1944, he examined tensions and contradictions in society that he believed contributed to schizophrenia. He looked at ward structure at Worcester State Hospital and found somewhat surprisingly, that it mitigated "the difficulties which the structure of Western civilisation creates for the potential schizophrenic".[1]

In a later paper he concluded that since the nature of mental disorder varies by culture, the mentally ill could best be treated in an environment which would resemble a society where their particular type of illness did not exist.[2] Clearly he was recommending that the characteristics of a special therapeutic 'milieu' should be seen to reflect the particular needs of different 'illness' types. In recent years this idea has found considerable acceptance amongst advocates of 'therapeutic community' methods.

The developing concern with the question of what was the right kind

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1 Devereux G. Social Structure of a Schizophrenic Ward and its Therapeutic Fitness. Journal of Clinical Psychopathology. 6, 1944 pp.231-265: Op.Cit: Perrow C. P.932.

2 Devereux G. The Social Structure of the Hospital as a Factor in Total Therapy Amer. Journal of Orthopsychiatry, 1949, 19 pp.492-500.

of institutional environment in which to treat mental disorders had the concomitant effect of publicising the defects of traditional hospital practices. The concern to show the negative aspects of custodial incarceration began to give rise to pessimistic interpretations of the future of institutional psychiatry.

A study carried out in 1946 at Columbus State Hospital, Ohio, showed that an 'employee culture' characterised the working relationships of hospital staff. Dunham and Weinberg interpreted this 'culture' as a collective defence against the custodial pessimism of institutional life, concluding that this negative atmosphere was a major factor working against patients' discharge.[1]

In 1948, Deutsch published the results of his examination of the American State Mental Hospital system concluding that living conditions and methods of 'treatment' were inhuman.[2]

He compared the atmosphere of the State Mental Hospital with the nineteenth century asylum, commenting that the old chains still existed in the form of narcosis, lobotomy and electro-convulsive treatments.[3]

During the early 1950's, a subtle change became noticeable in studies of the mental institution. Most important was the recognition by teams of social scientists and psychiatrists that merely pointing out the inadequacies of mental hospital techniques without any realistic alternative in mind, only contributed further to the pessimistic outlook. As a result, a series of important hospital experiments and studies combining social science techniques with psychiatric practices were undertaken with an emphasis upon providing answers to hitherto unresolved

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1 Dunham W. Weinberg S.K.: The Culture of the State Mental Hospital. Wayne State University Press. Detroit 1960 P.8.

2 Deutsch A. The Shame of the States. N.Y. Harcourt. Brace 1948.

3 Ibid. Deutsch A. quoted in Perrow C. Op.Cit. P.917.

practical and conceptual problems.

Stanton and Schwartz[1] sought to differentiate between forms of hospital organisation rather than to support or criticise custodial practices. This resulted in a classification stressing the differences between administration-centred and patient-centred forms of organisations.

Administration-centred organisation emphasises the importance of administrative rather than therapeutic tasks, and stresses that therapy can only take place within specified hours because it plays a secondary role in the hospital curriculum. Patient-centred organisation on the other hand, emphasises the therapeutic importance of the 'other twenty-three hours, which implies that the analytic hour has to be fully supported by the total resources of the hospital in order to ensure therapeutic effectiveness.

The major contribution of this particular study of Chestnut Lodge, 'a small proprietary hospital near Washington D.C., was that it looked at the hospital as a total culture as distinct from a 'total institution', in the sense that Goffman uses the term. Perrow comments that neither type of organisation advocates a form of 'milieu therapy' although a patient-centred ideology implicitly suggests that the hospital itself acts as a 'therapeutic agent'.[2]

Morris Schwartz later defined some of the essential characteristics of any 'therapeutic milieu' :

(i) Providing patients with experience that minimise their 'reality distortions'.

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1 Stanton A.H. & Schwartz M.S. The Mental Hospital N.Y. Basic Books 1954.

2 Perrow C. 1965 Op.Cit. P.940.

(ii) Facilitating meaningful, communicative exchange with others.

(iii) Facilitating participation with others leading to satisfaction and security.

(iv) The reduction of anxiety and the increase of comfort.

(v) The mobilisation of initiative in the patient to help him realise his potential for creativity and productivity.[1]

The overriding emphasis upon patient 'reactivation' reflects the acceptance of the idea that the mental patient should be an active participant in any therapeutic programme rather than a passive recipient of 'treatment'. One of the concepts to derive from this new emphasis upon patient participation and reactivation was 'rehabilitation' which stressed the possibility of restoring mental patients to a 'normal' status in the outside world.

The assumption that mental suffering could be alieviated as a result of participation in a therapeutic setting, resulting in discharge to the wider community, meant that for the first time 'treatment was linked to an attempt to understand the patient in his total life situation..."[2]

Stanton and Schwartz could be said to have been the pioneers of the systematic study of mental hospital organisations. They suggested, after extensive participant-observational involvement, that the behaviour of patients could be modified through the reorientation of staff-patient relationships and through the development of confrontation mechanisms to improve communication and the dehierarchisation of pyramidial authority

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1 Schwartz M. 'What is a Therapeutic Milieu'. In Greenblatt M. et al. The Patient and the Mental Hospital Free Press, Glencoe Illinois 1957.

2 Op Cit. Rapoport R.N. 1960 P.18

structures - all of which have since been built into models of 'therapeutic community'. Their theory of 'triangular conflict' which refers to unrecognised disagreements between administrators and therapists giving rise to pathological excitement and overt disturbance amongst patients, provided the justification for many attempts to improve the channels of communication in ward and hospital experiments during the late 1950's, and early 60's.

It should be remembered that 'The Mental Hospital' was first published in America in 1954 at a time when 'milieu therapy' was still regarded with suspicion, if not outright hostility. It is not surprising, therefore, that Alfred Stanton commented in 1956 that what was needed was a network of scientific theory in which to assess the means of effective institutional treatment. He explained that having established such a groundwork "it would follow that research in milieu therapy should be directed toward the increasingly accurate and specific identification of special patterns of interaction or transaction with other people which characterise various types of disorder".... Meanwhile, "Milieu therapy should be differentiated sharply from good custody (and) therapy from uninstructed humanitarian efforts".[1]

One series of research projects that sought to examine what Stanton referred to as 'special patterns of interaction; were those carried out by Caudhill between 1952 and 1958. Culminating in his now celebrated work 'The Psychiatric Hospital as a Small Society', he explained how patients, new to a psychiatric milieu, were 'taught' how to behave in hospital, that is, they were trained how to play the role of the patient

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[1] Stanton A.H. The Study of the Psychiatric Hospital as a Therapeutic Society. Centenial Papers. Washington D.C. St. Elizabeth Hospital 1956. pp.143-152. Quoted in Perrow C. Op.Cit. P.941.

by other longer-stay patients.[1,2,3] Such learning was said to indicate the existence of a 'patient culture'.

Caudhill maintained that this special culture emerged as a reaction to authoritarian control in the mental hospital, but argued, nevertheless that "It would be most unrealistic and probably unwise to attempt to circumvent the hierarchical arrangement that is characteristic of most psychiatric hospitals... (because) This is too deeply embedded in the already existing institutional system and in medical practice".[4]

Belknap studied the culture of an American State Mental Hospital which, despite certain basic reforms, still maintained its custodial, institutional structure. He found two groups of 'culture carriers', long term employees, such as attendants and maintenance officers, and long-stay patients. Roles were rigidly adhered to, reflecting a series of 'status layers' that characterised the differential distribution of privelages according to rank and seniority, in the status heirarchy of the hospital. Since doctors, for example, were accorded more privelages than patients, Belknap termed the phenomenon an 'employee culture'.

The similarities between the findings of Dunham and Weinberg, Stanton and Schwartz, Caudhill and Belknap are significant in that they indicate a growing awareness of alternative modes of institutional organisation and methods of treatment. Their studies pointed to the existence of different 'ideologies' in the institutional treatment of

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1 Caudhill W. et al. Social Structure and Interaction Processes on a Psychiatric Ward Amer. Journ. of Orthopsychiatry, 22, 1952, pp.314-334.

2 Caudhill W. Some Covert Effects of Communication Difficulties in a Psychiatric Hospital. Psychiatry 1954, 17, pp.27-40.

3 Caudhill W. The Psychiatric Hospital as a Small Society. Cambridge, Harvard UP. 1958.

4 Perrow C. Op.Cit. P.939.

mental disorders. As a result, the practice of contrasting 'custodial' with 'therapeutic' forms of mental hospital organisation began to gain acceptance amongst social scientists, psychiatrists and managerial personnel.

Some early examples of how change from 'custodial' to 'therapeutic' patient care was effected can be found in Greenblatt, York and Brown's account of what took place in three American hospitals during the early 1950's.[1] The Boston Psychopathic Hospital, the Bedford Veterans Administration Hospital, and the Metropolitan State Hospital are said to have achieved basic changes in the administration of patient care as a result of adherence to three new working hypotheses:

1. The basic function of the psychiatric hospital should be to use every form of treatment available for restoring patients to health and successfully rehabilitating them into the wider community. Failing this, the goal should be to help patients to live as nearly normal lives as possible within the institutional setting.

2. 'Therapy' required the systematic use of the whole environment consisting of both physical resources and social interaction between staff and patients.

3. For ensuring the effective use of social environment of the hospital, concepts and methods of research developed by the behavioural sciences should be tested and utilised wherever feasible.

Clearly, by the mid 1950's, some mental hospitals were beginning to undergo both structural and 'ideological' changes. The notion of the hospital as a social system combined with attempts to utilise the psychiatric milieu more effectively, added support to criticisms of

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[1] Greenblatt M., York R.H., Brown E.L. From Custodial to Therapeutic Patient Care in Mental Hospitals. Ressell Sage Foundation N.Y. 1955.

custodial practices. It was felt that custodialism promoted bureaucratic immobility, and hierarchical role structuring was said to lead to an over-emphasis upon task specialisation and an overdependence upon specific techniques. Successful rehabilitation was thought to depend upon a significant reduction in custodial methods coupled with an increasing awareness of the potential use of community health centres and half-way houses.[1]

Perhaps the most widely known of all studies of institutional behaviour and organisation are those of Goffman which were carried out between 1956 and 1962. It was his belief that mental hospitals, like monasteries, prisons and officers academies, were examples of what he termed 'total institutions'. They were all said to develop 'pathogenic' social features such as psychological isolation from the outside world, a system of special roles allied to rank and prevelage and a 'stripping process' whereby the entrant loses all things that previously formed his identity.[2]

Goffman's use of the term'pathogenic' in the above context stems from his assumption that a basic social arrangement of modern society is that we sleep, play and work in <u>different</u> places, whereas the central feature of the 'total institution' is a "breakdown of the barriers ordinarily separating these spheres of life". In place of choice, the individual is subject to the formal rulings of bodies of officials. Institutions such as these are, therefore, "forcing houses for changing persons in our society; each (of which) is a natural experiment on what

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1 Williams R.W. (ed) The Mental Hospital and the Community: Changes and Trends: The prevention of Disability in Mental Disorder. Public Health Service Publication No.924. Wash. D.C. U.S. Gov. Printing Office pp.35-8.

2 Goffman E. The Characteristics of Total Institutions. Walter Reed Army Institute of Research. Symposium on Preventive Psychiatry. U.S. Gov. Printing Office 1955.

can be done to the self".[1]

Goffman's assertion that custodial practices in mental hospitals have a detrimental effect upon patient welfare was borne out by Russell Barton in his analysis of the psychological effects of long-term incarceration. He claimed that after four years in hospital most patients suffer from two conditions:

(a) Schizophrenia and,

(b) 'institutional neurosis'.

The latter condition was described as 'secondary symptomatology' in that it derived from the negative effects of incarceration and was not diagnosable on admission to hospital. 'Institutional neurosis' was said to be characterised by a "loss of interest, especially in things of an impersonal nature, submissiveness, apparent inability to make plans for the future, lack of individuality and sometimes a characteristic posture or gait".[2]

Barton suggested that institutional neurosis could be overcome through the encouragement of the practice of rehabilitating patients into the wider community and by seeking ways of making hospital staff more aware of the conditions giving rise to neurosis.

The conclusion that can be drawn from these studies is that psychiatrists and social scientists had demonstrated an awareness that the quality of the psychiatric hospital environment left a great deal to be desired. Attention had been turned away from questions concerning the improvement of custodial techniques, towards alternative issues relating to an understanding of the potentially 'therapeutic' features of the psychiatric milieu. The shift in emphasis from 'custodial to therapeutic' patient care has been generously referred to

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1 Goffman E. The Mental Hospital as a Total Instiution in Cressey D.R. (ed) The Prison. Holt, Rinehart and Winston 1961.

2 Barton R. Institutional Neurosis.

in the literature on the mental hospital. What has not been explicitly dealt with, however, is the effect that this change has had upon the ideological statuses of both the older and the newer approaches to treatment.

Ideas, like clothes, go in and out of fashion. The durability of an idea or a theory will, therefore, depend to a large extent upon how appropriately it appears to 'fit' into prevailing currents of thinking.

The changes that took place in psychiatric theory and practice as a result of the exchange of ideas between social scientists and psychiatrists during the first half of the twentieth century helped to make possible the emergence of social-psychiatric approaches to mental disorders. However, as the emphasis upon 'environmental pathology' became fashionable after the second world war, a polarisation of models of aetiology and treatment began to emerge.

The accelerating pace of change characteristic of the 1950's and early 60's brought attention to bear upon the relative successes of social or 'milieu' therapy as distinct from less dramatic improvements in custodial techniques, with the result that the latter have tended to be regarded as synonymous with notions of 'bad' psychiatry, whilst 'therapeutic' models of patient care are seen to be representative of a new, 'progressive' psychiatry. The concept of the 'therapeutic community' emerged during this period of change, reflecting on the one hand, the optimism, and on the other, the lack of theoretical clarity that often characterises the innovation of new ideas.

The confusion that has subsequently become evident in attempts to define the nature and purpose of the terms 'therapeutic community' and

'milieu therapy' exemplifies the uncertainty felt by psychiatrists and social scientists over the issue of how to incorporate these newer, dynamically-oriented ideas into existing medical-psychiatric conceptions of the nature of mental disorder and the organisation of institutionally based programmes of treatment.

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CHAPTER 6

THE CONCEPT OF THE THERAPEUTIC COMMUNITY

In an article published in 1965, D. H. Clark referred to the 'therapeutic community' as "both an attitude and a method, a system of treatment and a battlecry, a charm and a password".[1] The enthusiastic manner in which these words are expressed bears witness to the sense of uniqueness that is generally ascribed to experiments in the use of 'mileu therapy' techniques in the treatment of mental disorders. The emotive use of such terms nevertheless hides an area of considerable theoretical confusion which in recent years has come to be regarded as something of a problem in the development of the social therapies. The absence of agreement over the meaning of key terms has led to over-generalisations and misinterpretations of the concepts originally advanced by such pioneers as Sullivan, Main and Jones.

For example, the term 'therapeutic community' has been used to describe the following groups of phenomena :- (to name but a few).

A West African Yoruba Village community,[2] the military, the school and the church,[3] the prison,[4-6] the remand home,[7] the halfway house,[8] rehabilitation centres for drug addicts,[9] social work community care programmes,[10] the wider social community,[11] the general hospital and the mental hospital,[12-15] psychiatric wards or wings of hospitals treating special groups of patients,[16-17] a mode of social therapy,[18] a model for group therapy and patient government,[19] the focus of a form of administrative therapy,[20-21] a psycho-analytically oriented hospital,[22] a 'socio-therapeutic' milieu for the treatment of psychopathy,[23] setting for multiple child-patient therapy,[24] admission units,[25] chronic wards in hospitals,[26] geriatric hospital care,[27] and, by allusion, 'corrective camps'.[28]

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[1] Clark D.H. The Therapeutic Community: Concept, Practice and Future. Brit. Journ. Psychiat. 1965, 111, pp.947-954.

[2-28] For references see end of chapter.

It was argued in the last chapter that changes in the organisational structure and management of psychiatric institutions, consequent upon changes in the conceptualisation of the nature of mental disorders, gave rise to new notions of 'patient responsibility' and a growing awareness of the 'therapeutic' potential of the hospital's 'social milieu'. The 1940's and 50's saw the growth, in both Europe and America, of experiments in the use of the group therapies,[1] forms of patient government,[2] and the manipulation of the psychiatric 'milieu' in 'total treatment' programmes.[3] The enthusiasm with which new ideas were put into practice often served to obscure the differences in meaning of concepts such as 'therapeutic community' and 'milieu therapy', although the one feature common to all these early experiments was the psychiatric setting in which they occurred.

One explanation for the generalisation of the term 'therapeutic community' to encompass non-medical settings is that during the 1960's the expansion of the psychotherapies beyond the medical psychiatric field made it possible for alternative forms of organisation to utilise these methods. The prison, the remand home and other correctional institutions began to incorporate psychotherpaeutic methods in their programmes no doubt in response to the critical findings of researchers such as Goffman who stressed the inhumane aspects of incarceration in 'total institutions'. The substitution of 'therapeutic' for 'custodial' forms of care rests on the assumption that it is 'more humane' to emphasise the patient's responsibility in treatment, than to assume the

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1 (a) W. R. Bion Intra-Group Tensions in Therapy.. Lancet 27th Nov., 1943 also Experiences in Groups and Other Papers. Tavistock 1961.
(b) Martin D.V. et al. An Experimental Unit for the Community Treatment of Neurosis Mental Science, 1954, 100 pp.983-9.

2 Hyde R.W. Solomon H.C. Patient Government: A New Form of Group Therapy. Digest of Neorology and Psychiatry, 18, 1950 pp.207-218.

3 Jones M. Social Psychiatry. Tavistock 1952. Clark D.H. & Hoy R.M. Reform in the Mental Hospital: A critical Study of a Programme. In. Journ. Soc. Psychiat. 1957, 3, 3, p.211. Martin D.V. Adventure in Psychiatry. Cassirer 1962.

right to act 'on behalf of' the patient by denying him that responsibility and substituting for it a regime of paternalistic care.

Numerous accounts of the beneficial effects of the 'social milieu' in treatment deriving from attitudinal surveys and comparisons of the morale of groups of patients in 'traditional' (custodial) and 'progressive' (milieu therapy) psychiatric institutions, have culminated in the belief that custodialism is synonymous with anti-therapeutic care.[1] Clark and Yeomans for example state that "Traditional organisation is geared to a biological and individual orientation. The ward is viewed as a place where patients are kept in cold storage until ready for the next treatment by various specialists, themselves isolated from the ongoing life and personnel of the ward. The atmosphere in the traditional hospital is anti-therapeutic".... therefore..... "A change in organisation is necessary to establish a community in which the impact is therapeutic; the concept of the therapeutic community requires... that the ward become the locus of treatment in which the interactions of all participants, including patients and staff of all ranks, are deliberately used to effect change in patients."[2]

Millon's analysis of theories of psychopathology would substantiate this viewpoint in that adherence to certain medical or psychological traditions is thought to give rise to quite separate fields of aetiological enquiry. "Followers in the tradition of psychiatric medicine focus on the biophysical substrate of pathology; those within the psychodynamic tradition deal with unconscious intrapsychic processes; theorists within the clinical-personology tradition often are concerned with conscious

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1 For list of references, see end of chapter.

2 Clark A.W., Yeomans N.T. Fraser House: Theory, Practice and Evaluation of a Therapeutic Community. Springer Pub. Co. 1969 P.3.

phenomenological experience; and those in the academic and experimental tradition attend primarily to overt behavioural data".[1]

Caine and Smail's analysis of the attitudes of psychiatrists and psychiatric nurses to treatment in mental hospitals, provides empirical support for the view that theories of psychopathology and methods of treatment tend to be consistent where the views of doctors and nurses reflect training influences, and particular aspects of hospital practice and culture. In reference to 'therapeutic community' methods, they claim to have shown that the way in which treatment is put into practice depends less on general theory than on the more specific views of the doctors and nurses who put it into practice." [2-4]

It seems reasonable to argue, therefore, that ideological differences have led to polarisations of models of psychiatric disorder and methods of treatment. Some notable examples of the use of dichotemous or multi-factorial explanations of psychiatric aetiology and treatment are those of Hollingshead and Redlich, Schatzman, Strauss et al, Willensky and Herz, and Edelson. Brief mention will be given to these ideas before going on to discuss the related issue of how 'therapeutic community' and 'milieu therapy' strategies have become linked with 'progressive' psychiatric ideas and how the terminological confusion derives from this trend.

Hollingshead and Redlich distinguished between two categories of psychiatric orientation in their epidemiological study of social class and mental disorder; these were, the (i) analytical and psychotherapeutic,

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1 Millon T. Theories of Psychopathology. W.B. Saunders Co. 1967 P.7.

2 Caine T.M., Smail D.J. Attitudes of Psychiatrists to Staff Roles and Treatment. Brit. Joun. med. Psychology 40, pp.179-182, 1967.

3 Caine T.M., Smail D.J. Attitudes of Psychiatric Nurses to their Role in Treatment, Brit. Journ. med. Psychology, 1968, pp.193-7, 41.

4 Caine T.M., Smail D.J. The Treatment of Mental Illness: Science, Faith and the Therapeutic Personality. Univ. of London Press. 1969.

and the (ii) directive-organic.[1] Their separation of psychodynamic from biophysical schools of thought clearly underlined the new direction in which psychiatric ideas had moved during the first half of the twentieth century.

Reflecting the considerable influence of the social sciences upon psychiatric thought during the 1950's and 60's, Strauss, Schatzman et. al., referred to three distinct ideological orientations; the (i) somatherapeutic, the (ii) psychotherapeutic, and the (iii) sociotherapeutic. They explain the significance of each of these by saying that "The clearest way to visualise each postulated ideology is through the eyes of a purist or one who is a strong advocate of the particular position. We should expect a high order of consistency in his views about the aetiology of mental illness, the nature and amount of treatment, prognosis and desirable treatment settings, including the structures and functions of institutions that house the mentally ill".[2]

Their expectations are in fact borne out by Wilensky and Herz in their examination of problem areas in a developing 'therapeutic community'. In this study they identify the concept of 'therapeutic community' with the 'sociotherapeutic' approach to treatment, which they claim has itself become "identified with progressive and presumably effective hospital treatment". Furthermore, they state that the 'custodial orientation' "which is portrayed as the antithesis of the therapeutic community or sociotherapeutic approach, is held responsible for the development of the hopeless, chronic, institutionalised psychotic". The nature of this 'antithesis' is explained as follows:-

"A critical difference between the sociotherapeutic and custodial orientation is postulated to depend upon the manner in which mental

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1 Hollingshead A.B., Redlich F.C. Social Class and Mental Illness. N.Y. Wiley & Sons 1958.

2 Strauss A., Schatzman L. et al. Psychiatric Ideologies and Institutions, Free Press, Glencoe, Collier-MacMillan 1964, P.55.

illness is conceptualised. The custodial orientation tends to view mental illness as similar to physical illness.... this conceptualisation depicts the patient as a passive, inert object to be acted upon by doctors, nurses and medicine in an attempt to remove the symptoms of the disorder..."

Whereas:-

"The therapeutic community model recognises the limitations of the physical illness analogy with its emphasis upon the treatment of the disease rather than the person".... and .... "in the sociotherapeutic approach the patient is assigned greater responsibility in controlling his own behaviour and in decision making procedures in the ward community".[1]

Edelson goes a stage further than Wilensky and Herz in defining the nature of the treatment enterprise within the 'therapeutic community'. Relying upon a functional 'systems' approach, very similar to that used by the Cummings in their analysis of ego building through environmental therapy,[2] Edelson attempts to explain how the restoration of the damaged ego can be successfully achieved through a realisation of the basic 'homology or correspondence' that exists between the "structure of the personality systems and its subsystems and the structures of external reality.... which impinges upon that personality".[3]

'Sociotherapy' and 'psychotherapy', two 'mutually reinforcing enterprises', are described as the means by which patients are treated

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1 Wilensky H., Herz M.I. Problem Areas in the Development of a Therapeutic Community, Int. Journ. Soc. Psychiat., 12 (4), 1966 pp.299-308.

2 Cumming J., Cumming E. 'Ego and Milieu! Theory and Practice of Environmental Therapy' Prentice Hall 1962, Tavistock 1964.

3 Edelson M. Sociotherapy and Psychotherapy. Univ. of Chicago Press. 1970, pp.3-21.

in the therapeutic community. 'Sociotherapy' refers to "a method of treatment, the focus of whose operations is the situation - particularly the social system in which the individual is treated". " 'Psychotherapy" on the other hand, is defined as "a method of treatment the focus of whose operations is the internal state or personality system of an individual". Edelson implies that the psychotherapeutic enterprise emphasises the 'internal' or psychological element in treatment, whereas the sociotherapeutic enterprise emphasises the 'external' or sociological element. This method of distinguishing between aspects of the treatment enterprise in reference to the 'therapeutic community', is not particularly new; Stainbrook pointed out in 1955 that the notion of the hospital as a 'therapeutic community' requires that psychiatry should view 'psychoanalytic theory' (intra-physic) and sociological theory (extra-psychic) as mutually reinforcing perspectives in the attempt to "extend the range of intellectual visibility and... the intelligibility of human behaviour in the hospital".[1]

The Cummings pointed out in 1962 that the reconstitution of the damaged ego takes place most effectively through crisis resolution in an unambiguous 'social milieu'.

Participation in the milieu involves a series of transactions in which the patient gains insight into his behaviour through the psychotherapeutic process and is enabled to 'take on' new roles and to test their effectiveness through social interaction. Elaine Cumming clarified this view in 1969 when she argued that 'therapeutic community'

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[1] Stainbrook E. The Hospital as a Therapeutic Community. Neuropsychiatry, 3, 1955 pp.69-87.

and 'milieu therapy' strategies can be distinguished according to the extent to which they stress the importance of either group psycho-therapeutic skill in conflict resolution, or means of improving the social performance of the patient. Both strategies are referred to as 'environmental' therapies, although 'therapeutic community' stresses that "resolving conflicts creates better performance" whereas 'milieu therapy' stresses that "better performance helps to resolve conflicts".

The implied psycho-therapeutic/socio-therapeutic distinction is finally made explicit in a comparison of the two types of therapeutic strategy: (a) therapeutic community refers to "all programmes that use group techniques to help the patient to understand and control his own emotional impasses".... whereas (b) milieu therapy, aims "at developing in the patients both diffuse and specific skills, or in other words, both social and instrumental competence".[1]

It is not difficult to imagine how terms such as 'milieu therapy', 'therapeutic community' or 'sociotherapy' can become interchangeable if one fails to understand the precise meaning implied by the writer. This criticism was, in fact, levelled against users of the term 'therapeutic community' by Zeitlyn, who argued that its meaning had become confused as a result of the imprecise and interchangible nature of terms such as 'milieu' therapy, 'relationship' therapy and, 'administrative' therapy. Discrepancies exist, he argued, between "the fantasies such phrases may stimulate and a more mundane reality". Moreover, continuing confusion may even have led to a "new discrimination and selection of patients and to the formation of a new group of rejected ones, excluded on the grounds that their symptomatology renders them

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[1] Cumming E. 'Therapeutic Community' and 'Milieu Therapy' Strategies Can be Distinguished. Int. Journ. Psychiatry, 7, (4), 1969 pp.204-208.

unsuitable for the permissive milieu characteristic of this form of treatment".[1]

In a critical appraisal of this argument, Cumming agreed with Zeitlyn that confusion reigned over the whole field of enquiry, but stated that the latter was incorrect in suggesting that terms such as 'milieu therapy' and 'therapeutic community' refer as often to fantasies as facts. Cumming preferred instead the argument that confusion exists because "we have a surfeit of facts, but too little taxonomy"... and therefore... until we have a systematic classification of the social therapies, our criticisms even though justified, may be too particular to have an impact on practice".[2]

In order to create the kind of taxonomy that Cumming envisages, one must nevertheless be able to define the categories into which these 'facts' can be slotted. In the case of the 'therapeutic community' it has become difficult to tell whether one is dealing with a form of organisation, a mode of therapy or simply a conceptual ideal-type construct. Therefore, before one can classify models or types a basic agreement must be reached over the question of to what the terms refer. From the foregoing analysis, it would seem that more concern is shown for declaring on which side of the theoretical fence the writer prefers to reside, than for attempting to establish clear criteria of definition. This brings us back to the issue of to what extent the terms 'milieu therapy', 'therapeutic community' and 'sociotherapy' are normatively linked with notions of 'progressiveness', anti-custodialism and the rejection of somatic theories of psychopathology.

In the early development of the social therapies it was sufficient

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1 Zeitlyn B.B. The Therapeutic Community - Fact or Fantasy? Brit. Journ. Psychiat. 1967, 113, pp.1083-1086.

2 Cumming E. Op.Cit. 1969 P.204.

simply to call an experiment in the use of the social milieu, a 'therapeutic community' or a mode of 'milieu therapy', because it represented a break from traditional psychiatric treatment practices. It has even been suggested that in its early days, the 'milieu therapy movement' represented the attempt to create an 'oppositional culture' within the mental hospital with the aim of restoring personal values, communication and meaning to depersonalised situations.[1]

As the reputation deriving from these experiments began to spread throughout the psychiatric world, the term 'therapeutic community' became linked with the 'progressive' aims of the new 'social' psychiatry. As a result of this trend, the application of the words 'therapeutic' and 'milieu' began to change in order to encompass a wider variety of meanings.

Traditionally, 'therapeutics' referred to that branch of medicine that deals with the treating or 'curing' of disease. Organic models of pathology provided the background against which physical methods were applied to 'diseases' of the body and the mind. However, the influences of the psychodynamic schools of thought in psychiatry, and the contributions to the epidemiology of mental disorders made by the social sciences, led to a partial acceptance of the role played by environmental factors in psychiatric aetiology. Jones, Sullivan, Main and a number of other experimenters in the uses of 'social therapy' as a factor in treatment, successfully attracted attention to the 'therapeutic', i.e. 'curative', potential of the social milieu.

A problem with the de-medicalisation of the word 'therapeutic' is that, unlike the medical definition, the social meaning of 'curative'

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[1] Rapoport R.N. 'The Therapeutic Community' in Mental Disorders, Treatment pp.207-214 of the International Encyclopedia of the Social Sciences. 1968, Crowell, Collier & MacMillan Inc. U.S.A.

does not satisfactorily bring to mind the factors responsible for the cure. Whereas a drug will usually produce a desired effect, a special community environment cannot expect any such degree of certainty between cause and effect. For this reason, generalisation and assumption have tended to take the place of 'fact'.

It was suggested earlier, that traditional custodial methods have come to be regarded by some writers as 'anti-therapeutic'. If one accepts this view, then the biophysical treatment orientation is, by qualification, anti-therapeutic as well. Furthermore, the assumption that certain kinds of psychiatric 'communities' are by definition 'therapeutic', implies that they have the 'power to cure', whereas traditional methods do not. In other words, the 'social' meaning of 'therapeutic' implies a model of treatment that is 'more progressive' (i.e. better than) than its medical counterparts.

If one now combines the word 'community', which means simply, 'a group of persons having a common identity or purpose',[1] with this definition of 'therapeutic', the conclusion that one comes to is that the term 'therapeutic community', refers to 'a body of opinion which states that social methods of treatment are more progressive than traditional methods of treating diseases'. The possibility of making such a general statement can only arise when the terms themselves are general in meaning or are taken out of their practical context. On their own they mean very little, and as a result they become open to distortion and misinterpretation. Take Pivnicki's interpretation of 'therapeutic community', for example; he states that "When we say 'therapeutic community', many of us tend to overlook the element of

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[1] See the Shorter Oxford Dictionary.

coercion in it which makes the morality of this procedure questionable". Like concentration camps, therapeutic communities have the intention of "changing the behaviour of a person against his will, with the pretext of correcting it".[1]

Furthermore, "Milieu therapy is very probably an offspring of this apprehension about the possible force and pressure behind the word 'therapeutic community'. The new term, however, has changed very little. If there is no change then 'milieu therapy' and 'therapeutic community' are synonymous....".1 Pivnicki may have oversimplified the meanings of these phrases, but it would not be possible to do this if these meanings were not already so general. Continuing with his analysis a stage further, he states that the word 'community' "in a slightly pessimistic translation, means 'to belong to a group which is subjected to the same duties and obligations" and the word 'milieu suggests "a middle way, the central line or course between two extremes". 'Milieu therapy' therefore means "the therapy which is trying to reduce everyone of us to an average".[2] Why he links these two words in a definition of milieu <u>therapy</u> is uncertain, to say the least, but it does enable him to conclude that "It seems, 'milieu' as a concept in psychiatry has not produced much beyond enthusiasm - certainly not any intensive and elaborate effort to study and develop methods of describing and defining the specific environmental influence".[3]

A secondary, though important issue that has a bearing upon interpretations of these key terms is the extent to which the writer is reflecting the particular ideological position of his own discipline.

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1 Pivnicki D. 1970 Op Cit. P.653.

2 Ibid P.654

3 Ibid P.657

In much the same way that Zeitlyn was criticised by Artiss for not having recognised that his psychoanalytic training biased his view of the therapeutic community,[1] Pivnicki fails to recognise that his defence of medicine in psychiatry prejudices his understanding of the role of the social sciences, in psychiatric practice. He does, however, admit that his paper "is an appeal to return to psychiatry and give up our amateurish naivete, which is pleasant but chimerical".[2]

These failings do not just apply to members of the medical profession, they also apply to social scientists who assume the existence of unambiguous structures and treatment approaches.

Perrow, for example, accuses social scientists of having helped foster the belief that by changing 'custodial organisations' into 'therapeutic communities' one also changes the values and goals of these institutions. The mistake that is made, he argues, is of confusing an 'ideology' with a 'technology'. Put simply, this means that the assumption of the therapeutic potential of the social milieu as an agent in treatment, makes the ideological purpose (treatment leading to 'cure') synonymous with the means (the use of the total resources of the 'milieu' in treatment) by which the condition of the patient is altered. Once again, the vagueness of meaning surrounding 'milieu therapy' and 'therapeutic community' allows for the criticism that theoretical orientation and methodological strategy are being confused. Perrow concludes that "The concept of 'milieu therapy' or 'therapeutic community' is not a new technology ('that which determines means available for attaining prescribed goals') to any significant extent, but is primarily a

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1 Artiss, K.L. A Narrow View of What is Therapeutic. Int. Journ. Psychiat., 7 (4), April 1969 pp.201-203.

2 Pivnicki D. Op Cit. P.665.

humanising influence. When taken as a technology it is apt to produce quite unanticipated results, promote unrealistic optimism, and lead to scientific generalisations which are erroneous and misleading. It is an attempt at treatment without technology and is bound to cause mischief in the scientific community".[1]

By now it should be clear to the reader that terminological confusion not only exists but has become a problem in the application of 'therapeutic community' principles to the treatment of psychiatric disorder. Reference to the works of leading contributors to this field of enquiry such as Jones, Clark, Martin and the Rapoports has so far been kept to a minimum so that the extent of the confusion can be guaged independently of attempts to advance comprehensive theories or practical solutions. A more systematic explanation of these ideas will now be undertaken with a view to showing how the confusion has arisen and how it is reflected in the literature pertaining to the therapeutic community.

(a) Maxwell Jones

Let us argue, for the sake of simplicity, that the concept of the 'therapeutic community' has been in existence for thirty years and derives much of its special character from the early communities established

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[1] Perrow C. Hospitals: Technology, Structure and Goals. In J.G. Marsh. Handbook of Organisations. 1965. Rand, McNally and Co. U.S.A. pp.910-971.

by Maxwell Jones at the Mill Hill Emergency Hospital, the Southern Hospital, Dartford and the Social Rehabilitation Unit at Belmont Hospital, Surrey. Treating mainly psychoneurotic and 'sociopathic' complaints amongst forces personnel, which included ex-prisoners of war, and later the 'chronic' unemployed, Jones discovered that in the absence of a full staff complement administering individual therapies, alternative methods, including community meetings and group discussions, could produce fundamental changes in patients attitudes towards their symptoms.[1] He found moreover, that this was not merely an educational experience, but affected the whole social structure of the hospital. Although treatment methods were highly eclectic, Jones insisted that 'treatment'itself was a continuous process that operated throughout the entire waking life of the patient. It was largely due to his successes in the use of the social environment that led to the distinctive assertion that "In a therapeutic community, the whole of a patients time spent in hospital is thought of as treatment...." and to be effective it..... "will not only involved the handling of an individual's neurotic problems, but also an awareness of the fresh problems which the fact of being in a neurosis hospital will create for the patient and what aspects of the social situation can be used to aid treatment. The patient, the social milieu in which he lives and works, and the hospital community of which he is temporarily a member are all important and interact on each other".[2]

This statement, is perhaps the most significant contribution to the entire literature of the therapeutic community and yet it has been abused, and misinterpreted so often since 1952, that its original meaning has been obscured. It is, therefore, useful to return to Jones' own stated

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1 Jones M. Social Psychiatry - A Study of Therapeutic Communities. Tavistock 1952.

2 Jones M. Ibid P.53 (my italics).

opinion in order to assess how he applied his concepts in practice.

In the case of the Mill Hill, Effort Syndrome Unit, he described the underlying principals of the enterprise as follows:-

1. Treatment is a continuous process, and operates throughout the waking life of the patient.
2. Open communication exists between doctors, nurses and patients, reflecting the.....
3. Non-hierarchical authority structure existing within the Unit.
4. Daily community meetings foster a sense of community identity.
5. Close scrutinisation of patient and staff roles is emphasised at all times.[1]

In the case of the later Social Rehabilitation Unit at Belmont, the social structure was characterised by:-

1. Daily community meetings attended by patients and staff.
2. Patient responsibility for committees and general social functions.
3. Staff role restructuring e.g. to include 'social therapists' untrained nurses with experience in the social sciences.
4. Horizontal authority structure rather than pyramidial authority - facilitating open communication through the relinquishing of status traditionally ascribed to the roles of doctor, nurse and patient.

All of these features combined to form what Jones termed the 'social milieu' of the hospital. The 'processual' nature of treatment simply reflected an awareness of the potential contribution that a liberalised social structure and an introspective culture could make to patient progress. Within such a culture, the patient was offered the opportunity

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[1] Ibid pp.14-15.

of assuming partial responsibility for both his treatment and that of others.

The question of what factors combine to bring about a 'cure' was subsumed under the general notion of 'everything being therapy'. Unfortunately, for many doctors, this kind of approach appeared to be extremely vague and far too easy to misinterpret. Medical training emphasises the need to understand the links between treatments and their expected results, but in the case of the 'therapeutic community' or 'social milieu' hypotheses, no clear methodology and no standardised means of evaluating 'success' were being advanced. The use of the environment as an agent in therapy was therefore an unorthodox notion and those attempting to adopt it as the basis of a distinctive treatment approach had to be able to accept the pluralistic view of cause to effect in treatment and cure, as well as being able to deal with potentially threatening situations arising from the discarding of traditional attitudes and roles. For this reason, the comparative success of some therapeutic community experiments over others, probably owes more to the charismatic personalities of some senior doctors than to any other individual factors.

The success of Jones' early work derives from his personal ability to convince others of the validity of his ideas. Despite the fact that many of his basic principles were originally expressed in the most general of terms, he is rarely criticised for not having been more specific.

It is significant that at no time has he attempted to define <u>what</u> a therapeutic community is, although he has, on a number of occasions stated to what he believes the term can be most appropriately applied.

For example, in 1959 he stated that the implication of the term

'therapeutic community' is 'healing', and that its practical application is "distinctive among any institutional unit in the way that the institutions total resources are self-consciously pooled in furthering treatment".[1]

In 1960, he showed that he was aware of how others were failing to understand the concept of the therapeutic community when he commented that it "has tended to be used in so many ways that its meaning has become vague and confused. Nevertheless, it is becoming increasingly clear that the social environment of psychiatric patients, whether in hospital or in the outside community, can have a profound effect on their readjustment and eventual recovery".[2]

In the first of two 1968 publications, he stated that "The term 'therapeutic community' originally applied to psychiatric hospitals or special units with a particular type of social organisation. Instead of the familiar hierarchical, authoritarian organisation associated with hospitals in general, the 'therapeutic community' aimed at a more democratic, egalitarian type of social structure. The aim was to bring about the optimal use of the potential within staff, patients and their relatives for the betterment of the patient population".[3] In his article he outlined "five fundamental concepts of the hospital therapeutic community",

1. Two-way communication,
2. Decision making machinery encompassing all levels of hospital organisation,

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1 Jones M. Towards a Clarification of the Therapeutic Community Concept., Brit. Journ. Med. Psychol. 32, (3), 1959.

2 Jones M. Introductory remarks to R. N. Rapoport et al 'Community as Doctor'. Tavistock 1960.

3 Jones M. Therapeutic Community Principles within the Hospital and in the Outside Community. (Proc. of 7th Int. Congress of Psychotherapy. Wiesbaden 1967. Part 11 Community Psychiatry - Therapeutic Community. Psychotherap. Psychosom. 16, 84-90, 1968.

3. Strong leadership (not authoritarian power),

4. Consensual patient-staff decision making,

5. Social learning (analysis of social interactions, free expression of feelings).

In the second of these publications he seemed to be warning against the dangers of overspecialisation of terms when he argued that there is no one model of the therapeutic community, therefore, "All that we hope to do is to mobilise the interests, skills and enthusiasms of staff and patients and give them sufficient freedom of action to create their own optimal social organisation. Under such circumstances, what emerges will be appropriate for that particular group and will possibly have little in common with other 'therapeutic communities'".[1]

(b) Misinterpretations, reinterpretations and further developments

For Jones, the 'therapeutic community' concept was the expression of an attempt to understand and to utilise the total physical, social and psychological resources of a given psychiatric environment in treatment and rehabilitation. For others, however, it has either tended to be interpreted as a model upon which organisational structures are based, or used as a general psuedonym for experiments in the use of milieu therapy techniques.

There are a variety of reasons why this concept has become so diversified. One concerns the re-interpretation of Jones' ideas to suit wider conceptions of the therapeutic potential of the social milieu.

It was mentioned earlier that Cumming distinguished 'milieu therapy', from 'therapeutic community' according to the emphasis placed upon either psychotherapeutic activity or concern over the improvement of the patient's

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[1] Jones M. Social Psychiatry in Practice. Penguin. London 1968 also published in the U.S.A. under title : Beyond the Therapeutic Community. Yale Univ. Press 1968.

social functioning, and Stainbrook, Edelson and Wilensky and Herz made similar distinctions between activities that are essentially concerned with 'intrapsychic', psychological of psychotherapeutic aspects of treatment and 'extra-psychic', sociological or socio-therapeutic aspects of participation in a social milieu. Stauble[1] has since provided an interesting, though misleading, analysis of this tendency to separate 'community' and 'milieu' strategies. He explains that over the years three distinct ways of understanding the relationship of an individual to his milieu have emerged. These are:-

1. The Therapeutic Community approach - in which events are analysed in terms of their intrapsychic significance.
2. The milieu therapy approach - in which situations are analysed from the point of view of their social appropriateness and the use of social skills.
3. The therapeutic milieu - which is concerned with ward and hospital organisation and interaction.

The first of these is said to encompass the early experiments of Main, Bion, Foulkes and Davidson in which group psychotherapeutic methods were used extensively in a deliberate attempt to use the hospital as a therapeutic institution. The primary aim of this approach was thought to be the "resocialization of the neurotic individual for life in society".

The 'milieu therapy' approach is distinguished from the 'therapeutic community' approach through its greater concern with "the development of skills on a conscious and interpersonal level than with the development of insight and intrapsychic modification". Surprisingly, Stauble includes

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[1] Stauble W.J. 'Milieu Therapy and the Therapeutic Community' in a Symposium entitled 'Evaluation of Psychiatric Services'. Canadian Psychiatric Assoc. Journ. Vol. 16, No.3, June 1971, pp.197-202.

Maxwell Jones within this category along with the Rapoports, D.H. Clark and Cumming. He explains that Jones' early work at Belmont Hospital was more concerned with rehabilitation, that is, social reorientation, than with intrapsychic integration. The Rapoports in their study of Jones' 'Social Rehabilitation Unit' are also said to have been more concerned to show that rehabilitation, defined as "those measures which have as their immediate aim the fitting of a particular personality to the demands of the ongoing social system",[1] was "an approach which stressed the development of social and work skills". Similarly, Clark's distinction between the 'therapeutic community approach' and the 'therapeutic community proper'[2] is compared to the Rapoports notions of rehabilitation, (social orientation) and treatment (intrapsychic re-organisation) as is Elaine Cumming's distinction between 'milieu therapy' and the 'therapeutic community' which stressed the different goals of improving social competence through participation in a healthy milieu, and increasing intrapsychic integration through methods of conflict resolution.

Stauble's third category, the 'therapeutic milieu' could be said to represent all those studies that have emphasised the importance of general social factors in the environment of the psychiatric hospital. He mentions Myerson's 'Total Push' programmes of the 1930's and Sullivan's use of the milieu in the treatment of schizophrenia; Stanton and Schwartz' analysis of conflict and failure of communication between staff as it revealed itself in the pathological behaviour of patients,

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1 Rapoport R.N. et al. Community as Doctor: New Perspectives on a Therapeutic Community. Tavistock 1960 P.28.

2 Clark D.H. Administrative Therapy: The Role of the Doctor in the Therapeutic Community. Tavistock. 1964 (Mind and Medicine Monographs No.9 Ed. Michael Balint).

and Herz' notion that all patients exist in some kind of 'milieu' anyway, so it is more important to distinguish which features are therapeutic from those which are not.[1]

Rapoport has adopted an alternative classificatory scheme for this particular group of studies. He prefers to distinguish 'holistic' and 'segmental' methods of clarifying concepts which, for example, would separate his own 'holistic' study of a 'total' 'therapeutic community' from Stanton and Schwartz' 'segmental' study of aspects of a psychiatric hospital milieu. In general he tends towards the viewpoint that "Rather than asking what a therapeutic community is, and how well it works, the questions are (now) being posed in terms of what aspects of the approach are most relevant for what types of persons under what conditions, including conditions of concurrent use of other forms of therapy".[2]

The point at which Stauble's analysis becomes misleading is where he tries to distinguish 'therapeutic community' from 'milieu therapy' by separating those accounts of experiments which emphasise, as their primary goal, intrapsychic integration as distinct from social reorientation. Although the separation of 'psychotherapeutic' and 'sociotherapeutic' factors is a valid one, the way in which he assigns the labels of 'therapeutic community' or 'milieu therapy' to the work of the writers mentioned, is often incorrect.

For example, to say that Maxwell Jones belongs to the 'milieu therapy' group because the Mill Hill, Dartford and Belmont experiments emphasised the social rehabilitation of patients with character disorders as their primary goal, misses the essential character of Jones' inter-

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1 Herz M.J. The Therapeutic Milieu: A Necessity. Int. Journ. Psychiat. 7, pp.209-212, 1969.

2 Rapoport R.N. Op Cit 1968 P.214.

pretation of the therapeutic potential of the social milieu. The 'therapeutic community' was the total manifestation of treatment and rehabilitation enterprises, in which intrapsychic integration was carefully fostered within the psychotherapeutic hours[1] and reinforced through the interaction of patients and staff in ward and community meetings. Without the former, social rehabilitation would have had no meaning.

This point of view is clearly explained by Jones when he refers to the rehabilitative enterprise as "any treatment situation in which psychological, sociological and anthropological techniques can be applied with advantage to the individual whether he be recovering from an illness, has reached a static state of disability, be deteriorating or simply maludjusted to a degree which would not commonly be designated illness".[2] Furthermore, if one holds that Jones' ideas do not exemplify at least one of the original concepts of the 'therapeutic community' then there seems little point in making any distinctions at all. Every method of using the therapeutic potential of the social milieu could, under these circumstances, be referred to as aspects of the approach known as 'milieu therapy'. Judging from comments in the literature it would seem that other writers have shown that they do not think that this should be the case.

The Rapoports use of the terms 'treatment' and rehabilitation' is similarly misinterpreted by Stauble. Although in their study of Jones' Social Rehabilitation Unit they distinguish between these two processes, they nevertheless make it clear that 'milieu therapy' is 'focal in the

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1 Freeman T. Some Problems in In-Patient Psychotherapy in a Neurosis Unit. Chapter V of Jones M. Social Psychiatry 1952 pp.69-84.

2 Jones M. Psychiatric Rehabilitation. Report to the W.H.O.(mimeo) in Rapoport R.N. 1960 Op Cit P.24 (my italics).

unit' because it is 'total', meaning that "every aspect of hospital life is regarded as relevant and potentially therapeutic".[1] For this reason, when they claim that "Different kinds of therapeutic milieu will probably be most effective for different kinds of patients with different kinds of staffs under different administrative systems,"[2] they are not arguing that the 'rehabilitation' process is solely concerned with the milieu therapy enterprise as distinct from the 'treatment' process which concerns itself with the task of intrapsychic reorganisation within the 'therapeutic community'.

Stauble's assertion that Clark's distinction between the therapeutic community 'proper' and the therapeutic community 'approach' is similar to that made by the Rapoports also mistakes the theoretical purpose underlying Clark's work. Apart from the fact that he would probably find the term 'milieu therapy' inappropriate as a description of his basic orientation, Clark is mainly concerned to clarify the role of the doctor in the therapeutic community, which he describes as the practice of 'administrative therapy'. This role combines two activities often seen as being antagonistic, (i) psychotherapy, and (ii) administration; that is, "psychological treatment combined with planning, sitting on committees, dealing with regulations and paperwork". Furthermore, "administrative therapy borrows greatly from psychotherapy and particularly group analytic psychotherapy" and despite the inevitable problems involved in the joining of the two enterprises "both are concerned with using psychological means to enable a disturbed individual to achieve a better balance between his internal and his external life".[3] Thus the

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1 Rapoport R.N. Op Cit 1960, pp.28-9.

2 Ibid pp.268-304

3 Clark D.H. Administrative Therapy 1964 Op Cit pp.120-1.

administrative therapy enterprise aims to combine rather than to separate psychotherapeutic and sociotherapeutic methods of treatment. For this reason it is misleading to distinguish the therapeutic community 'proper' from the therapeutic 'approach' on the grounds that the first, which refers to "a small face-to-face intensive treatment facility with extensive social restructuring" is more concerned with intrapsychic integration, than is the second which "is a way of looking at the life of patients in any psychiatric institution and restructuring their lives".[1]

The conclusion that can be drawn from this analysis of Stauble's views is that therapeutic community and milieu therapy strategies cannot be clearly distinguished in terms of the goals of improving intra-psychic integration or improving social skills. There are either too many exceptions to the rule or it becomes too difficult to distinguish, qualitatively, between methods belonging to one or the other approach.

What does, however, emerge is the fact that an increasing number of attempts have been made to explain what the 'therapeutic community' is not, rather than what it is. This seems to derive from the relative lack of success in re-interpretting the ideas of Jones and others to suit dissimilar psychiatric situations and from the difficulty in comparing 'therapeutic' features of different milieux.

The Rapoports' attempt to define the major characteristic of the treatment ideology at Jones, Social Rehabilitation Unit is a useful case in point. They compressed the basic features, outlined by Jones, into four conceptual categories (i) Democratisation (ii) Permissiveness (iii) Reality Confrontation, and (iv) Communalism.[2]

'Democratisation' which refers to community responsibility in

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1 Clark D.H. The Therapeutic Community - Concept Practice and Future 1965, Op Cit P.948.

2 Rapoport R.N. 1960 Op Cit P.269.

treatment and administrative decision-making, is widely thought to underpin most 'therapeutic community' projects. The Rapoports' state, however, that "Democracy is valuable therapeutically but is incompatible with the goals of rehabilitation, therefore, it is impossible to arrange patient participation so as to recognise the real structure of formal authority and discrete requirements of treatment and rehabilitation".[1] In a summary of their work, Perrow claims that their use of terms such as 'democratisation' and 'permissiveness' is "too subtle to be clear in practice"[2] - a point of view borne out in the literature by other writers with first-hand experience of problems in the development of therapeutic community principles,[3,4,5] In fact, Raskin has stated that "In the early phase of a therapeutic community, democracy and permissiveness do no seem to be effective immediate goals" nor, for that matter, is 'role blurring therapeutic' in all communities at all times.[6]

Whereas Jones suggested, rather than categorically stated that democratically-oriented processes and permissive social structures were an integral part of the cultures of his communities, the Rapoports have perhaps unintentionally promoted a belief in the ideological necessity of such processes to the therapeutic community. In consequence, more recent attempts to define these concepts have led to further confusion

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1 Ibid P.287 (my italics)

2 Perrow C. Op Cit 1965 pp.941-5.

3 Bierenbroodspot P. Democratisation in the Mental Hospital as a Therapeutic Vehicle. Psychotherap. Psychosom. 20 pp.143-7, 1972.

4 Leyton H. Et al. Therapeutic Communities & Admission Centres. What of the Future? Op Cit 1968, pp.663-4.

5 Herz M.I. The Therapeutic Community A Critique. Hosp. & Community Psychiatry, 23, 3, March 1972, P.70.

6 Raskin D.E. Problems in the Therapeutic Community. American Journ. of Psychiat. Oct. 1971 128, (4) pp.492-3.

as to whether communities lacking any of these four ideological orientations should be referred to as examples of 'milieu therapy', 'therapeutic community', therapeutic community 'approach' or whatever.

Even within each of these sub-definitions, further complications arise. For example, when D. H. Clark speaks of the therapeutic community 'proper' as deriving from Maxwell Jones original ideas, and the role of the 'administrative therapist' as being the 'physician's task in the therapeutic community', it is somewhat confusing to discover that Crockett links the therapeutic community 'approach' with the work of Jones, and 'administrative therapy', as distinct from 'clinical', 'supportive' and 'medical' administration, with the evolution of this 'approach'.[1] The explanation for this stems from Crockett's differing interpretation of Jones' notion of the 'therapeutic community' and a more precise view of the role of the doctor in the construction of the 'therapeutic' programme.

On the first of these, he comments that: "In recent years a tendency has developed to describe the successful mental hospital as a therapeutic community. There is however, confusion over what is actually meant by this phrase. No definition seems to have been reached and often only a vague notion of benevolent intention is conveyed, involving rehabilitation as well as custodial care in the mental hospital. The 'Therapeutic Community approach' to treatment is a difference matter, however, and is a well-understood clinical administrative procedure of a special kind. It is described extensively in this country by Maxwell Jones".[2]

With respect to Crockett, the therapeutic community 'approach' is

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1 Crockett R.W. Doctors, Administrators and Therapeutic Communities. Lancet, Aug. 13th 1960 pp.359-363.

2 Ibid pp.360-1 (my italics).

hardly a 'well understood' procedure if the same phrase can be used by a senior colleague to describe a different treatment orientation. And if Clark and Crockett can respectively relate the therapeutic community 'proper' and the therapeutic community 'approach' to the work of Maxwell Jones, this either implies that Jones' ideas were so general that they encourage misinterpretation or so unique that they do not stand comparison with other methods. Furthermore, it is difficult in the light of these different interpretations to know how 'administrative therapy' relates to the therapeutic community when one is confronted by such statements as "The concept of the therapeutic community as the creation of an administrator is considered to be fallacious and is contrasted with the therapeutic community 'approach' to treatment which is regarded as a skilled, clinical, administrative technique".[1]

It is hard to escape the conclusion that <u>as a general concept</u> the 'therapeutic community' is ambiguous and confused. Despite numerous attempts at clarification it is still possible to find it being referred to as 'a battlecry, a charm and a password' (Clark), a humanising influence (Perrow) a technique (Crockett) or a 'coercive practice' (Pivnicki). Although it is true to say that when each study is assessed on its own merits it becomes a simpler task to understand how each writer has defined his terms, it is nevertheless still the case that the use of the term 'therapeutic community' to encompass <u>all</u> definitions necessarily requires that its interpretation remains flexible.

This brings us to an important juncture in our analysis of the concept of the therapeutic community. Judging from the differences

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[1] Ibid P.363.

between modes of explanation in the general literature it would appear that two major groups can be specified which approach the concept by different means; The first group seeks to explain the concept by definition of the ideas and theoretical principles contained within it, whereas the second group assumes the existence of a distinctive therapeutic community concept by qualification.

1. Therapeutic Community by 'definition'

This title refers to those explanations of experimental studies in the use of community and milieu therapy methods that use the term 'therapeutic community' to describe theoretical models, actual working examples, the use of specific techniques or any other special characteristics of the psycho-social milieu.

Examples of the kinds of studies or experiments that would fit into this group are those of Jones, Clark, Crockett, Martin, Wilmer, Whiteley, the Rapoports, Clark and Yeomans and Muzekari. One could argue that Jones, Martin, Wilmer and the Rapoports all viewed the therapeutic community from the point of view that it represents the total utilisation of resources of (usually) a relatively small functioning psychiatric unit. Wilmer[1] ran a 34 bed acute admission ward along the lines established by Jones (1952), Martin specialised in the reconstruction of hospital wards or villas to facilitate the treatment of neurotic and psychopathic disorders and defined the therapeutic community as "one in which a deliberate effort is made to use to the fullest possible extent in a comprehensive treatment plan the contribution of all staff and patients",[2] whereas Jones, along with the Rapoports, first described smaller hospital units, then later, on his own, he extended his concept to encompass a

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1 Wilmer H.A. Social Psychiatry in Action. C.C. Thomas Springfield. Illinois 1958.

2 Martin D.V. Adventure in Psychiatry. Cassirer. Faber and Faber 1962.

300 bed psychiatric hospital.[1]

Clark describes the utilisation of Jones' ideas in his concept of the therapeutic community 'proper', which in practice refers to his experiments in the reorganisation of acute, and later, chronic wards in an 800 bed psychiatric hospital near Cambridge.[2] Here, as in the case of Crockett's experiments, the concept of therapeutic community represents the utilisation of administrative-therapeutic techniques in specially constituted milieux. Clark defined the therapeutic community (proper) in 1964 as "a fairly small (30-100) group of patients and staff living and working together and attempting to change the patients faulty social functioning to a more satisfactory adjustment by means of various social techniques which include regular community meetings, analysis of social events, role examination and restructuring and examination of communications; to this process all members of the community, nurses, ancillary workers and patients, as well as doctors, have a considerable contribution to make".[3]

Whiteley has shown how, since its days as the Social Rehabilitation Unit, the 64 bed Henderson Hospital has developed into a special therapeutic community for the treatment of psychopathic disorders. The psychotherapeutic process emphasises the importance of providing "a regressive situation in which the early social learning experiences of the five to ten year old can be repeated. The affective emotion-experiencing subject is able to become involved in this situation and use it productively to restructure his interpersonal relationships and

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1 Jones M. Social Psychiatry in Practice 1968, Op Cit.

2 Clark D.H. Myers K. Themes in a Therapeutic Community. Brit. Journ. of Psychiat. 1970, 117, pp.389-95.

3 Clark D.H. The Developing Concept of the Therapeutic Community. Op Cit. 1965, P.244.

behaviour in a more personally satisfying and socially acceptable way".[1] The social structure and ideological base to the community remains, however, very much the same as it was when the Rapoports carried out their study in the late 1950's, despite statements to the contrary.[2] Whiteley makes it clear that "From its inception the Unit has shown an ability to respond to changing social needs... the ability for self-examination evaluation and change without collapse is what the therapeutic community is all about, whether applied to individual members or the total social group".[3]

If the original principles underlying the creation of this unit can still be said to apply to the culture of the Henderson Hospital it would suggest that, as an example of one model of therapeutic community practice, this one has an enduring structure.

Clark and Yeomans have drawn extensively from the ideas of Jones in their study of Fraser House, a 78 bed psychiatric hospital in New South Wales. Their 'total treatment' model emphasises the importance of such features of community ideology as:-

1. Flattening of the authority hierarchy.
2. Community, rather than staff control.
3. Community, not 'specialist' responsibility for treatment.
4. Patient self government.
5. Open communications at all levels.
6. Viewing the community as a microcosm of wider society.[4]

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1 Whiteley J.S. The Response of Psychopaths to a Therapeutic Community. Brit. Journ. Psychiat., 1970, 116, pp.517-29.

2 Morrice J.K.W. Review of 'Community as Doctor' Brit. Journ. Psychiat. June, 1968 p.792.

3 Whiteley J.S. Reply to J.K.W. Morrice 'Letters' - The Therapeutic Community. Brit. Journ. Psychiat. Vol.114, Aug. 1968, pp.1508-9.

4 Clark A.W. Yeomans N.T. Fraser House, 1969 Op Cit. P.4.

Once again, what gives this therapeutic community its special quality is the 'atmosphere' generated by an awareness of the potentially therapeutic aspects of all its constituent factors.

Not all writers on the therapeutic community, however, have been able to claim that 'treatment' implies the full utilisation of all available resources, because some communities may not have the necessary administrative or clinical autonomy to put new ideas into practice. Therefore, one tends to come across descriptions of experimental treatment situations that are called 'therapeutic communities' yet bear little resemblance to any of the better known approaches.

Muzekari[1] has attempted to provide a means by which these kinds of theoretical models can be classified according to type of social organisation. He stresses that the mistake made by most exponents of the therapeutic community is of paying too much attention to the description of general goals and day-to-day functioning and too little attention to the nature of the therapeutic community as a system or subsystem within an organisational context. He advances four models that view the therapeutic community as:

1. A total social organisation - in which administrative and clinical functions are combined in the attempt to use the entire social structure of the institution as a 'therapeutic force'.

2. A functional subsystem of a larger organisation - in which the "community' comprises a ward, wing or building. Collaberation between administrative and clinical elements is central to the inception of this kind of community.

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[1] Muzekari L.H. The Therapeutic Community and the Mental Institution. A New Perspective Psychological Reports 1970, 26, 1, pp.79-82.

3. An autonomous, encapsulated organisational structure - these tend to be known as 'demonstration projects' because they function semi-autonomously within the total institutional structure and 'service' a limited number of 'selected patients'. Here, clinical and administrative goals are not usually congruent.

4. A special experiment not sanctioned by the larger institution - characterised by limited experimental procedures, usually at ward level, of short duration only, and sometimes openly opposed by the larger institutional body.

As a means of distinguishing types of organisation this is quite a useful classificatory system, although it does not help one to define what it is about the therapeutic community that is 'therapeutic'.

The first category describes the 'hospital' as a therapeutic community - exemplified by Jones' Belmont and Dingleton Communities, Clark and Yeoman's Fraser House project, and Mallers' Pardessia hospital experiment with chronic mental patients.[1]

The second category probably represents the largest group of projects calling themselves 'therapeutic communities'. Martin's special wards at Claybury hospital, treating the psychoneuroses, Clark's acute wards at Fulborne hospital, Leyton's special acute Admission Unit in New South Wales, and various other specially organised short and long term psychiatric units (Quattlebaum J.T. 1967, Heaht P.J., 1971; Gottlieb B.M. 1971)[2] are all examples of an ever-expanding group of smaller communities within larger hospitals that claim to have adopted therapeutic community principles.

The third category describes approaches to treatment that other

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[1] Maller J.O. The Therapeutic Community with Chronic Mental Patients. Bibliothena Psychiatrica. No.146, 1971, S. Karger A.G. Switzerland.

[2] See references at end of chapter.

writers would probably describe as 'milieu therapy' techniques. Stanton and Schwartz, for example, described the kind of approach in which administrative and clinical goals were often in conflict in the evolution of therapeutic programmes, and Conran,[1] has emphasised the difficulties encountered in the establishment of a special ward programme for the treatment of schizophrenic patients when the hospital body to which he was responsible held ambivalent views towards 'therapeutic community' methods.

The fourth category cannot really be said to describe 'therapeutic community' methods at all, in that these kinds of experiments are usually limited in scope and do not carry the sanction of the hospital administration.

Examples of this kind of organisation should, in strict terms, be included in our second main theoretical grouping 'therapeutic community by qualification'. (MacCarthy, for example, holds that "It is not possible to develop a therapeutic community in a mental hospital ward if it were a Unit in total isolation..... because..... the ward community is <u>part</u> of the total hospital).[2]

Muzekari's models are intended to simplify the task of distinguishing <u>types</u> of therapeutic community. They are essentially theoretical constructs which can be used for the purpose of comparing organisational structures and methods.

If it is the case that therapeutic communities vary in nature and scope according to the differential degree of institutional support

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1 Conran M.B. The Family as a Model in an Application of Psychoanalysis to the Care and Treatment of Young Male Schizophrenics. Unpublished M.D. Thesis 1970. Univ. of London.

2 MacCarthy B.F. An experimental Study of the Social Matrix of a Psychiatric Ward; its potential Value in Treatment and Rehabilitation. M.D. Thesis (Unpub.) 1960 Napsbury Hospital, Herts.

for the principles underlying their formation, comparative techniques will have to be developed to take account of differences in managerial and administrative policy between hospitals and variations in the selection of criteria used by doctors and social scientists in their definitions of therapeutic community. (An attempt to go part of the way towards analysing the comparative views of medical and non-medical personnel on the nature and functions of the therapeutic community concept is described in the chapter on research findings; Part 3, Chapter 8.)

2. Therapeutic Community by 'qualification'

Included in this category are those studies or descriptions of experiments in the use of community and milieu therapy methods which assume the existence of a generally understood concept of 'therapeutic community' by qualifying their premises and interpreting their results in terms of it.

The early use of the term as a kind of general psuedonym for special milieu therapy experiments is quite understandable in that it was more important to show that psychiatric methods were not custodial in orientation than to provide a definitive explanation for a new kind of approach to treatment. Hence those studies that emphasise the importance of the change from custodial to therapeutic patient care have tended to refer to the therapeutic community as a polar-type of treatment philosophy.

Hirschowitz, for example, described his success in the development of teamwork, the introduction of community meetings, and the delegation of responsibility for treatment from doctors to nursing personnel, as

being due mainly to a realisation of the need to improve upon traditional custodial methods and authoritarian attitudes.

On the theory behind his innovations, he comments that, "In addition to Maxwell Jones' therapeutic community ideology, we hope to incorporate some Szaszian notions and some Menningerian concepts. For work in the field of ego and milieu I consider the Cummings text to be admirable".[1] This kind of explanation illustrates the extent to which therapeutic community principles are assumed to be universally comprehensible.

Other notable examples of treatment programmes assuming the title of therapeutic community includes those of Amberg[2], who describes the initiation in an alcoholism centre, of a series of proposals including patient government, despite the fact that they "did not know that (their) efforts would result in change leading to the therapeutic community concept"; and Grauer, whose interest in changing the environment of a geriatric hospital led him to the conclusion that the 'milieu' "should be one in which each patient functions at his own optimal level with some degree of choice and determination"... because "if approached in this manner the 'therapeutic community' can be a useful treatment modality in geriatric settings".[3]

A different goup of studies which tend to imply the universality of the therapeutic community concept are those that claim the right to use it as a term representing proof of success in the evolution of therapeutic programmes.

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1 Hirschowitz R.G. From Chronic Wards to Therapeutic Communities. 1. Preparing and Developing Staff. Hospital and Community Psychiatry, 18, 1967, pp.304-310.

2 Amberg R.G. From Traditional Institutional Management to the Therapeutic Community. Concept: One Hospital's approach to change. Medical Annals of D.C. Vol. 40, 10, 1971 pp.644-648.

3 Grauer H. Institutions for the Aged - Therapeutic Communities? Univ. of the Amer. Geriatrics Society, Vol.19, No.8, 1471 pp.687-692.

Farmer[1], for example, describes how the maintenance of authority rather than an emphasis upon democratisation played an important part in his success in establishing a 'therapeutic community'; and Gralnick and D'Elia[2] have shown how the extension of individual psychoanalytic psychotherapy to groups, 'on many levels', not only gives a 'therapeutic quality' to the whole hospital but allows for the inference that such changes in treatment modality enable a psychoanalytic hospital to be referred as a 'therapeutic community'.

Often, only aspects of hospital practice are referred to which are said to take place 'in a therapeutic community' when, in fact, very little about the latter is known. For example, Weymouth et al, describe how community meetings "proved effective as a means of understanding patient interaction and as a tool in creating a supportive milieu...." and yet nothing is said about the principle features of this 'developing therapeutic community'. It is assumed that a description of the 'chronologic history of events' taking place on 'the open floor of a small hospital' somehow qualifies the experiment as a therapeutic community.[3]

It may be that these writers details the principles of their communities elsewhere, but one rarely finds references to such publications. Even the most interesting discussions of specific aspects of life in a 'therapeutic community' such as those described by Bradshaw (1972), Esquibel and Kort (1969) and Morohn (1967).[4] can be misinter-

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1 Farmer R.G. Establishing a Therapeutic Community 1969 Op Cit P.926.

2 Gralnick A., D'Elia F. A Psychoanalytic Hospital Becomes a Therapeutic Community. Hospital and Community Psychiatry 20, 1969 pp.144-146.

3 Weymouth R.N., Taintor Z., A Group Cycle in a Developing Therapeutic Community. Int. Journ. of Group Psychotherapy 18, 1, 1968 pp.75-85.

4 See chapter references.

preted unless one accepts a highly generalised view of the concept.

The largest group of studies which involve general assumptions about the nature of the therapeutic community are those which specialise in attitudinal and value changes of patients in response to difference treatment regimes. There are, unfortunately, so many different views of which characteristics of milieu therapy constitute a 'therapeutic community', that comparisons of findings are made almost impossible. Miles, for example, states that the 'special features of the therapeutic community' are its 'permissive atmosphere', 'democratic organisation', 'spirit of enquiry and helpfulness' and found that attitudes of patients towards hospital staff underwent a great deal of change in the therapeutic community that she studied compared with the attitudes of a control group that were housed elsewhere.[1] Haveliwala et al, on the other hand, after having compared patient attitudes towards treatment in a 'traditional ward' and in a 'therapeutic community ward involving two-way communication, liberalised decision making machinery and role restructuring, concluded that there was no significant change on either ward "after exposure to the (special) ward milieu".[2]

We need not be concerned at this point in time with either the methods or the results of these studies, but instead with the conceptualisation of the milieu in which the research was carried out. In the latter study, no adequate definition of what they mean by 'therapeutic community' is provided and one can only conclude that they assume they are dealing with therapeutic community principles by a process of qualification. (Further references to these kinds of attitudinal and

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1 Miles A. Changes in the Attitudes to Authority of Patients with Behaviour Disorders in a Therapeutic Community. Brit. Journ. Psychiat. 115, 1969, pp.1049-57.

2 Haveliwala Y.A. et al Therapeutic Community - Patient Attitudes. Psychiatric Quarterly. Vol. 45, no.4, 1972 pp.490-497.

value-change studies can be found in the chapter notes).

A number of sociological studies of the mental hospital, patient culture and characteristics of ward programmes also tend to imply that the term 'milieu therapy' and 'therapeutic community' are generally understood. For example, in a study of effects of ward settings on psychiatric patients, Moos[1] set out to prove empirically that characteristics of the ward milieu have differential effects upon the patient's understanding of his situation. He claims that Rapoport, Wilmer and Fairweather all assumed that a ward setting will have similar effects upon patients in general, citing their examples of group anxiety at meetings, the general effectiveness of the ward meeting and consistently different patterns of behaviour between different ward treatment programmes. His own findings seem to show that these writers overlooked important aspects of patient responses to the milieu. The research setting was a Veterans Administration Hospital in America treating psychoneurotic disorders, in which "open communication in multidirectional pathways, qualified permissiveness and active patient participation were encouraged" and "Community meetings were held five days a week and small group therapy four days a week...."

Despite comparisons with other 'therapeutic community' projects, Moos does not refer directly to the term in reference to his own study; instead he prefers to talk about the 'milieu' in which therapeutic change takes place. The implicit assumption underlying this analysis, therefore, appears to be that therapeutic community strategies are part of the wider 'milieu therapy' movement.

Finally, in a study of 'milieu characteristics of psychiatric treatment programmes', Ellsworth et al[2] found, to their dismay, that there

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1 Moos R.H. Differential Effects of Ward Settings on Psychiatric Patients. Nourn. of Nervous and Mental Disease. Vol.145, 4, 1967, pp.272-283.

2 Ellsworth R. et al. Milieu Characteristics of Successful Psychiatric Treatment Programmes. American Journ. of Orthopsychiatry. 41, 3, April 1971 pp.427-441.

were no special factors such as patient-involvement in ward management, inaccessibility of staff or satisfaction with the ward, that could be clearly linked with the success of one model of ward management as compared to another.

They had expected to find that certain aspects of different milieux would be favourably linked with success in treatment, since an introductory statement claimed that 'milieu therapy means very different things to different people'. Maxwell Jones' work is compared to that of other experimenters in the use of therapeutic community techniques, yet Ellsworth and his colleagues refer to all of these approaches to treatment as 'uses of the milieu', which although not incorrect, nevertheless implies that milieu therapy is synonymous with 'therapeutic community'.

Conclusions

From the foregoing analysis of the literature on the 'therapeutic community', it can be concluded that as a general concept its meaning is vague, confused and ambiguous. At almost every level of enquiry its nature, type scope and function escape adequate definition, with the result that almost any vaguely 'progressive' attempt to include the environment of the psychiatric setting in notions of 'treatment' can be interpreted as an example of a therapeutic community.

Ironically, Maxwell Jones' concern to show that there is 'no one model of the therapeutic community' seems, on reflection, to be an inadequate way of preserving the flexibility of meaning of the concept. If one is to adopt this very general kind of stance then it must also be accepted that a therapeutic community and the therapeutic community 'concept' are quite separate entities. After all, what is 'therapeutic'

to some may not be 'therapeutic' to others, therefore a therapeutic community is a specifically understood relationship between organisational structure, ideological purpose and immediately available resources that can be utilised in the attainment of goals specific to that particular community.

The therapeutic community 'concept' on the other hand may well be fallacious in that it requires a body of ideas and propositions over which there can be common agreement concerning meaning and application. Since particular definitions do not readily apply to other community functions, and given that terms such as 'milieu therapy' and 'therapeutic milieu' account for most interpretations of the use the environment of a psychiatric setting as a factor in patient progress, the place for a general concept seems curiously lacking, and attempts to provide a clear rationale to support it, somewhat inappropriate.

So long as attempts are made, and reasons found to denounce traditional custodial practices, grounds will exist for mobilising interest in new techniques and new ways of using the psychiatric environment in treatment. It may well be, however, that change has taken place to such an extent that the initial phase of enthusiasm for the 'therapeutic community' is over and what has taken its place is a gradual amelioration of the ideas contained within the general approach into many areas of institutional psychiatric practice. There is no doubt that individual communities function with success despite the differences between them, which would suggest that the problem concerning the therapeutic community is semantic and conceptual, rather than organisational. Whether an approach to treatment is 'socio-therapeutic', or 'psychotherapeutic' for example, will rarely alter the fact that the organisation in which it takes place is medical and will generally

involve the use of eclectic methods.

It is in the nature of change that as one accepted practice becomes outmoded or falls into disrepute, another takes its place, until it too is superceded by something else. It could be argued that confusion and generalisation concerning the therapeutic community concept has arisen because its initial applications to practical settings have lost their immediate impact in the sense of representing the 'new approach' to treatment, with the result that reformulations and extensions of these ideas have led to a loss of clarity of meaning. Herz exemplifies this trend when he states that "In the United States there has been an enthusiastic, uncritical acceptance of the principles of the therapeutic community introduced by Maxwell Jones and others, and no progressive hospital worth its salt would be without the label of therapeutic community. But there are many areas of confusion about the concept, including its definition, implementation and results".[1] This implies that in order to be seen to be 'progressive', a hospital must, whatever its organisational structure or ideological position, call itself a 'therapeutic community'. Furthermore, when viewed from this point of view the general concept of the therapeutic community seems to cover forms of organisation, methods of treatment and attitudes towards mental disorder, much as Clark has suggested.[2]

It is not enough to argue that a new idea or practice is bound to go through an initial period of confusion before clear principles can be worked out to suit all situations, because the treatment of mental disorders, once released from a 'disease model' and traditional modes

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1 Herz M.I. The Therapeutic Community : A Critique. 1972, Op Cit P.69 (my italics).

2 Clark D.H. 1965, see opening paragraph of chapter 6.

of hospital organisation, does not readily fall into a scientifically - objective framework of theory and practice. The links between diagnosis, treatment and 'cure' have become less certain with the movement away from medical models of mental illness. Cause and effect cannot be so easily established where a 'social' model of disorder is posited, nor for that matter are they so important given that 'environmental therapy' is viewed as a process through which the patient gains insight into the origins and effects of psychological disorientation.

Despite these changes the same basic expectations remain in reference to treatment; in particular to the provision, nationally, of services designed to cater for the psychiatrically disordered within a medically-oriented framework, although admittedly in closer co-operation with community care facilities. For example, Abel-Smith wrote in 1962 that "In the case of our mental patients, who are nearly half of all our hospital patients, we have decided to bring them all within the curtilage of our general hospitals. This... was a decision based on principle. He wanted to teach the public to regard mental illness in the same way as they regard any other illness".[1] In the light of the debate over 'medical' or 'social' models of mental disorder this kind of statement which, epitomises the position adopted by the Department of Health and Social Security over the question of psychiatric hospital services nationally, can only serve to limit the extent to which the non-medical psychotherapies and socio-therapeutic techniques are allowed to expand throughout, and perhaps beyond the present psychiatric field.

Whereas in 1960 there were eighty-two psychiatric units attached to general hospitals, by 1975 it was planned that this figure should have

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[1] Abel-Smith B. 'Hospital Planning in Great Britain', Hospitals, Vol.36, 1st May, 1962 P.33.

grown to one hundred and sixty eight. Commenting upon this trend, Rehin and Martin explain that this kind of unit suits "Shorter stay patients... whose prognosis is good, where illness is not yet so chronic as to involve lengthy rehabilitative measures and who can be expected to improve quickly in response to 'aggressive' treatment".[1] Given this kind of background it is not difficult to understand how socially oriented methods of treatment must reach a point in their development where they either break away from medical practice or themselves become institutionalised both in organisation and theory.

In the face of a widening gap between Social Policy and individual innovation in psychiatric practice, it may well be that the confusion surrounding the concept of the 'therapeutic community' exemplifies a lack of fit between the theoretical goals established by exponents of this approach and the practical means of attaining them.

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PART 3

FIELD RESEARCH: ANALYSIS OF THE OPERATIONAL USAGE OF THE CONCEPT OF THE THERAPEUTIC COMMUNITY

INTRODUCTION

In Part 1, attention was focussed upon the application of sociological ideas to psychiatric phenomena and the support claimed for the emergence of a distinctive Sociology of Psychiatry. In Part 2, the concept of the Therapeutic Community was examined in the light of (i) the historical evolution of psychiatric care methods (ii) the interchange of social scientific and medical views on the origins and treatment of mental disorders, and (iii) the contemporary confusion surrounding its general interpretation and application to existing methods of treatment and forms of organisation.

From the foregoing analysis of the literature pertaining to the 'therapeutic community' (Chapter 6) it should now be fairly clear to the reader that considerable scope exists for further research into the conditions giving rise to therapeutic community methods and the conceptions of therapeutic purpose, structure and goals held by patients and staff, particularly as these contribute towards a general clarification of the overall concept.

In Part 3 an examination of the author's field research will be undertaken with a view to elucidating the concept of the therapeutic community and presenting a series of proposals for the systematic study of such treatment milieux.

Basic Aims and Purpose of Research

In March 1971, the first stage of a two-part research study was initiated. The purpose of this stage was exploration, and was concerned with the task of ascertaining, from a representative sample

of all grades of staff working in six specially selected psychiatric settings,

(i) What criteria they would use to define the nature, function and goals of the 'therapeutic community', and

(ii) how 'therapeutic communities' differed from (a) each other, and (b) other modes of psychiatric treatment organisation.

The reason behind the selection of this particular range of respondants derives from a sense of dissatisfaction with existing statements concerning the aims, purposes and functions of therapeutic communities in the literature referred to in previous chapters. It was felt that statements and definitions by senior medical staff were, to a certain extent, unrepresentative of the general attitude towards the therapeutic community held by nursing staff, administrative and non-medical professional groups all of whom play as significant, if not a more significant role in the life of such communities.

It was decided quite early in the preparations for field study that the most appropriate method of data collection, given the wide range of respondants and problems of spending adequate amounts of time in each setting, was the pre-arranged interview schedule, in which 133 interviews, comprising a series of 33 questions were delivered to all grades of staff during the course of a standardised 45 minute interview. (More will be said about the construction, delivery and findings of the interviews in the relevant section on research data).

The period of time taken to complete these exploratory interviews was six months during which six establishments all around the country were visited. These were (in order of sequence) Fulborne Hospital, Cambridge, Claybury Hospital, Essex; Shenley Hospital, Herts; The

Northgate Clinic, Middlesex; Henderson Hospital, Surrey; and Dingleton Hospital, Roxburghshire, Scotland. The amount of time spent in each hospital varied between two and five weeks depending upon availability of staff and the period of time required to get to know people and for them to feel free to be interviewed.

The second major stage of field research was initiated in September 1971 and was concluded in March 1972. It involved the study of an evolving 'therapeutic community' in an external Villa of a large mental hospital near London. The aims of the study comprised:

(1) an assessment, by means of participant observations, of the changing ideas, aspirations and behaviours of patients and staff during the course of modifications to the social and organisational structure of the Villa.

(2) an attempt, through the use of specially designed behavioural, attitudinal and graphical measures to assess patients' interpretations of the therapeutic and social regimes during the course of the changes mentioned in (1) above.

(3) an attempt to ascertain the effect of instituting a 'therapeutic community' programme in a hospital still largely 'conventional' in organisational structure and medical policy.

The general aim of this research concerns the elucidation and clarification of the concepts of the therapeutic community in British institutional psychiatry.

STAGE 1 - EXPLORATION : INTERVIEWS IN SIX THERAPEUTIC COMMUNITIES

CHAPTER 7

BACKGROUND ISSUES AND ORGANISATION

1. Research Design : Theoretical and Methodological Considerations

"Research"... claim Millon and Diesenhaus, "is a process of enquiry that employs both informal and systematic methods of observation; (and) its goal, broadly speaking, is to explore, describe and confirm empirical relationships and scientific hypotheses..." however, they continue, "Not all enquiry is research. What distinguishes research from 'common-sense' enquiry is that it is systematically related to an orderly body of knowledge, derives it impetus from that knowledge, and is executed in accord with certain scientific principles and procedures".[1]

Faced with the problem of deciding whether one's research topic warrants the kind of systematisation to which Millon and Diesenhaus refer, the social scientist must have a clear idea not only of how the theoretical principles and methodological strategies of his own discipline can be adapted to suit the subject matter of psychopathology, but also, to what extent his ability to become involved in the subject field is restrained or curtailed by his lack of specialised knowledge, absence of relevant skills or unfamiliar professional status. After all, what is a 'common-sense' statement to a psychiatrist may be a source of confusion to a sociologist who is in the process of refining his conceptual ideas.

This is particularly the case in reference to the 'therapeutic community'. It was pointed out in the last chapter how the term has

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[1] Millon T., Diesenhaus H.I. Research Methods in Psychopathology. John Wiley and Sons Inc., 1972 P.6.

been used to denote a multitude of different things and how one definition that is thought to be generally understood can, in fact, be taken to mean something else. To the sociologist this kind of confusion presents a double problem. One the one hand he has to decide upon the psychiatric meaning and application of the term, while on the other he is required to clarify the sociological interpretation well enough in the preliminary stages of investigation to be able to construct an adequate research design.

For various reasons the concept of the therapeutic community eludes systematic conceptualisation. Firstly, the subject matter is neither orderly nor objectively clear; secondly, of the studies that have been undertaken in 'therapeutic communities', opinions concerning nature, purpose and goals vary considerably and do not make for easy comparison. Finally, of the studies that have been acclaimed the greatest successes, such as the Rapoports' 'Community as Doctor' and Clark and Yeoman's 'Fraser House', the questions investigated and the methods used, have been so different that replication and generalisation are virtually impossible. Furthermore, the material deriving from them cannot be ordered in such a way so as to be able to claim the existence of a body of scientifically validated propositions about the therapeutic community.

Is the sociologist to assume, therefore, that his work does not constitute genuine research? or does he seek to find a methodological alternative that allows for the grounding of common-sense notions, 'hunches' and hypothetical ideas in the process of data accumulation? In the case of the 'therapeutic community' the choice of theoretical approach and methodological strategy, is to a considerable extent,

predetermined by the vagueness of the subject matter. A research design has to be flexible enough on the one hand to enable the sociologist to probe and examine highly subjective phenomena, and structured enough on the other to meet the basic requirements of objective validation.

In Part 1 it was argued that 'dualism' in the methodology of the human and social sciences has, in the past, served to obscure or limit the importance of subjective factors with the result that 'objective' procedures for verifying data have been overemphasised in research designs. It was further shown how Gouldner, Szasz, Main and others have expressed dissatisfaction with the polarisation of methods of acquiring knowledge in which the collection of factual 'information' is contrasted with the acquisition of knowledge through direct subjective involvement.[1]

Concern with such questions, however, has helped to provide greater support for experimentation with more interpretive, qualitative methodological procedures in social research, as exemplified for example in Glaser and Strauss' 'Grounded Theory'.[2] The kind of theory that they advance is particularly useful to the sociologist working in a conceptually confusing area because they do not over-emphasise the need for objective verification procedures. Theory, they claim, is grounded in the data, and hence the adequacy of a theory in Sociology cannot be divorced from the process by which it is generated. Inductive methods of theory building are thought to be more relevant to qualitative research

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1 See Part 1, Chapters 1 & 2.

2 Glaser B., Strauss A. The Discovery of Grounded Theory : Strategies for Qualitative Research. Weidenfeld & Nicholson 1968.

than logico-deductive methods, because it is assumed that they reduce the risk of aimless fact finding and the need for ex-post fact generalisation.

The sociological study of psychopathology relies to a large extent upon the collection of qualitative information and often requires the active involvement of the researcher in the field of his own study. For this reason, it is important to select or develop methods of data collection that will complement the theoretical assumptions that arise during the course of research. The two works mentioned in connection with theory building and research methods in psychopathology, those of Glaser and Strauss, and Millon and Diesenhaus, provide the theoretical background to the present study. Both will be referred to during the course of explaining the nature, purpose and functions of the two separate stages of field study.

2. (a) The Role of the Sociologist in the Mental Hospital

One of the major problems facing the sociologist when he enters a psychiatric hospital for the purpose of carrying out research is that everything is unfamiliar and, as was mentioned earlier, his status in relation to medically trained personnel is left open to interpretation. This can mean that acquiring information through direct participation or through the use of techniques that require the voluntary involvement of hospital staff, becomes both a lengthy and difficult process. The role of the sociologist in medical care research can vary considerably according to the extent to which the staff with whom he is working favour his approach, value his involvement or understand his purpose.

Denman and Ruffin, for example, believe that the discipline of sociology has modified greatly over the past 30 years and has discarded

its purely 'academic' image for an 'applied' role in many areas of social life. Referring to its applications to psychiatry they state that sociology "Can be applied to patient care, particularly to creating a milieu that helps psychiatric patients overcome psychopathological behaviour and learn healthy, adaptive behaviour...", but this new 'applied' role of the Sociologist "does not mean that he should abandon his unique professional skills and become an amateur psychiatrist... Rather, in serving as a contributing member of a multidisciplinary therapeutic team he should use his academic and research skills to apply sociological knowledge to the psychiatric milieu".[1]

Zborowski, referring to the same issue, openly states that the most frequent question that the social scientist must answer in a medical setting is "What are you doing in our hospital?" which is indicative of the traditional, though understandable defensiveness of the medical and nursing professions towards interference from outside their disciplines. He goes on to define three broad areas of hospital life in which the role of the social scientist is particularly important; (i) the social and cultural dimensions of patient care as provided by the medical and paramedical professions (ii) the network of interpersonal and inter-professional relationships within the hospital to provide the most effective interaction for diagnosis, treatment and recovery, and (iii) to medical and paramedical education where the sociocultural framework can be added to the understanding of the patient's responses to his illness and treatment.[2]

Smedby, on the other hand, believes that social scientific research

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1 Denman S.B., Ruffin W.C. The Sociologists Contribution to Milieu Therapy: Hosp. & Community Psychiatry 19, 1968 pp.79-80.

2 Zborowski M. The Social Scientist as a New Member of the Hospital Team. Hospitals (J.A.H.A.) 1967 Vol.41 pp.66-8.

can aid the development of teamwork in psychiatric and general medical care but views the role of the sociologist as that of providing information to aid doctors and social workers rather than becoming actively involved in the processes of therapy.[1]

Judging from the opinions of both these writers and those referred to during an earlier discussion of these questions,* there is certainly no clear consensus of opinion about the role of the sociologist in socio-medical research and for this reason one of the purposes of the exploratory work about to be described, has been to assess the potential problems that can be encountered in working with special groups of respondants, as well as in the construction of a research design.

3. Methods of Data Collection

Millon has developed four methodological approaches from his original theories of psychopathology.[2] Biophysical, Intrapsychic, Phenomenological and Behavioural. Of these, phenomenological research methods are of particular interest to the sociologist because they enable the study of conscious experience from the subjective frame of reference.[3]

Although the methods that he describes were largely designed for research in social psychology, they can be applied with similar ease to the sociological study of psychiatric phenomena. Three procedures for gathering phenomenological data are advanced; (i) interviewing (ii) self-report inventories, and (iii) performance measures. It will be shown how the first and last of these methods have been included in the general research design.

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1 Smedby B. The Role of the Sociologist in Medical Care Research. Acta Socio-Medica Scandinavia. 1971, pp.187-196.

2 Millon T. Theories of Psychopathology W.B. Saunders Co. 1967.

3 Millon T. Diesenhaus H.I. Op Cit 1972 P.96

* See Chapter 3, Part 1.

It was decided that for the purposes of exploratory work the first of the three methods, interviewing, would enable the researcher to gather information about the 'therapeutic community' relatively quickly and with the least degree of difficulty. An interview schedule was constructed containing 33 questions that were to be addressed to staff only, in a selection of psychiatric settings already utilising the term 'therapeutic community' to describe aspects of their organisational and treatment approaches.

Although the questions were pre-arranged in a manner that would facilitate simple post-interview analysis, they were not so rigidly structured, that specific classes of data could be read off and finite conclusions drawn from them. The interviews were designed to provide a general view of the 'therapeutic community' as defined by the staff working in such settings, and to help to generate further theoretical propositions that could be included in the second stage of research. In this sense, Stage 1 was not intended to prove anything; it was instead designed to gather material together that could suggest what it is about 'therapeutic communities' that gives them their special character.

Glaser and Strauss explain the rationale behind this mode of enquiry. They warn against getting 'hooked' on the need to verify one's data during the early stages of research, preferring instead the view that the "generation of theory through comparative analysis both subsumes and assumes verifications and accurate descriptions.. to the extent that the latter are in the service of generation".... however "When generating is not clearly recognised as the main goal of a given research it can be quickly killed by the twin critiques of accurate

evidence and verified hypotheses".[1]

Given this comparative freedom to experiment with theoretical ideas, "the sociologist with theoretical generation as his major aim need not know the concrete situation better than the people involve in it".[2] This is particularly useful for the researcher engaged in work in hospitals where concern is often expressed over the absence of relevant knowledge, status and skills.

4. Selection of Respondant Groups and Hospitals

The initial choice of hospitals in which the exploratory interviews were carried out was determined to a considerable extent by practical factors such as available funds to cover field work expenses; the length of time offered to the researcher by each hospital, which was sometimes not long enough to satisfy the basic requirements of random selection of respondents; the need to travel considerable distances to ensure a relevant selection of 'therapeutic communities' - as in the cases of Dingleton Hospital in Scotland and Fulborne Hospital in Cambridge.

Getting permission to visit a hospital did not mean that a free rein was provided to the researcher once he was there. Quite understandably, a sociologist asking a lot of questions about a subject that arouses suspicion and hostility amongst some hospital staff, is not always a welcomed visitor. This is not to say that hospital personnel were inhospitable. To the contrary, the work of the researcher was received with interest and understanding. Only on one or two occasions did problems arise over the interviewing procedures; for example, where a

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1 Glaser B., Strauss A. Op Cit 1968 P.28.

2 Glaser B., Strauss A. Op Cit 1968 P 30.

member of staff declined to be interviewed no further approaches were made; or in the case of one psychiatric wing of a general hospital, the 'community' voted that the researcher could only participate in certain specified activities, and would have to interview at specified times.

(a) The Hospitals

As was pointed out in the last chapter, the term 'therapeutic community' can be used to describe many varying types of psychiatric settings. It was, therefore, decided to select six 'types' of therapeutic community from a wide range of organisations throughout the British Isles. Adopting a similar method of classification of 'types' of organisation to that of Muzekari[1], it was decided that factors, such as size, degree of managerial autonomy, nature of patient population and stated aims should be taken into account during the process of selection. The following list of hospitals includes the reasons for their choices:-

1. Fulborne Hospital, Cambridge (March 1971)

A 765* bed psychiatric hospital extensively restructured under the direction of Dr. David Clark in which certain wards are designated therapeutic communities 'proper' as distinct from the hospital's overall therapeutic community 'approach'. The setting chosen for interview purposes was Hereward House, a sexually integrated ward set back from the main body of the hospital, containing 25 beds and housing, at the time of visiting, 18 patients and 16 staff. Although situationally independent of the main hospital this ward was still managerially, and to some extent medically dependent upon it. The staff interviewed, consisted of:-

Medical Personnel — Consultant Psychiatrist (1)

Registrar (1)

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[1] Muzekari L.H. See Reference List, 44, Chapter 6, Part 2.

* All bed complement figures are taken from the 'Hospitals and Health Services Year Book - 1974'. (Institute of Health Service Administrators) and represent the total bed complement at 31/12/72.

Administrative and Non-Medical Personnel	Principle, Deputy, Senior Nursing Officers (3)
	Psychiatric Social Worker (1)
Nursing Staff	Charge Nurse (1)
	Sister (1)
	Staff Nurse (5)
	Nursing Assistant (2)

Diagnostic Grouping: Patients manifesting symptoms of acute behavioural or personality disorder.

2. Claybury Hospital, Essex (April, 1971)

A 1688 bed psychiatric hospital serving part of the London Metropolitan catchment area having gained its reputation as a 'therapeutic community hospital' during the late 1950's and early 60's, when it was under the administration of Dr. Denis Martin. Although generally thought to have 'modified' considerably since that time, certain wards within the main body of the hospital are thought to be run along the lines of 'small unit therapeutic communities'.

The settings chosen for interview purposes were wards, M1, N1, and O1.

(a) Ward M1 Mixed admission ward of eclectic treatment orientation using the term 'therapeutic community' to describe a general approach to the treatment of acute disorders. Thirty beds, twenty patients, seventeen staff, fourteen of whom were available for interview.

Medical Personnel	Consultant Psychiatrist (1)
Administrative & Non-Medical Personnel	Social Workers (2)
	Occupational Therapist (1)
Nursing Staff	Charge Nurse (1) Sister (1)
	Staff Nurses and Postgraduate Student Nurses (6)
	Student Nurses (2)

Diagnostic Grouping: Acute disorders during admission to hospital.

(b) Ward N1 Mixed admission ward of eclectic treatment orientation, and like M1, using the term 'therapeutic community' to describe a general approach to the treatment of acute disorders. 32 beds, 25 patients, 16 staff, 13 of whom were interviewed.

Medical Personnel	Consultant Psychiatrist (1)

Administrative & Non-Medical Personnel	Social Workers (2)
	Occupational Therapists (1)
Nursing Staff	Postgraduate Student Nurses (3)
	Student Nurses (3)

Diagnostic Grouping: Acute disorders during admission to hospital.

(c) Ward 01 Mixed admission ward of eclectic orientation serving same catchment area and like M1 and N1 using the term 'therapeutic community' to describe a general approach to the treatment of acute disorders. 32 beds, 24 patients and 15 staff, all of whom were interviewed.

Medical Personnel	Consultant Psychiatrist (1)
	Registrar (1) Doctor (Physician) (1)
Administrative & Non-Medical Personnel	Social Workers (2)
	Occupational Therapist (1)
Nursing Staff	Charge Nurse (1)
	Sister (1)
	Staff Nurse (2)
	Student Nurses (5)

Diagnostic Grouping: Acute disorders during admission to hospital.

3. Shenley Hospital, Hertfordshire (April-May 1971)

A 1781 bed hospital serving a north and west London catchment area. One of the 'newer' mental hospitals having been opened in 1936 only to be given the task of dealing with the 'excess' chronic populations of two other London hospitals. In consequence Shenley has had to counter criticisms that it is 'old fashioned' and 'traditionalistic' in treatment orientation. In fact, a psychodynamic orientation is quite evident in methods of treatment throughout the hospital and from within this tradition two ward experiments could be said to have originated; these are Villa 21, and Woodside Villa.

(a) Villa 21 A 'special' villa sited not far from the Central hospital administrative buildings, containing 18 beds, 7 staff and 17 patients, mostly young male schizophrenics undergoing a psycho-

analytic experience in a 'therapeutic community' based upon a 'family' model.

Medical Personnel	Medical Assistant (1)
Nursing Staff	Charge Nurses (2)
	Student Nurses (2)

2 members of staff were unavailable for interview.

Diagnostic Grouping: Young male schizophrenics in varying phases of adolescent and post adolescent breakdown.

(b) Woodside Villa Another 'special' villa sited on one boundary of the hospital's grounds, relatively isolated from the main body of the hospital, though dependent upon it organizationally.

Chosen as the subject of the second stage of research due to the interest being shown at the time in adopting 'therapeutic community' procedures and ideas. Unlike other communities visited by the researcher, Woodside was the only one in which the patients, both male and female, had private bedrooms.

The villa had, at the time of the initial interviews, over 20 beds, 11 staff, of whom 8 were available for interview, and 18 patients.

Medical Personnel	Registrar (1)
Administrative & Non-Medical Personnel	Social Workers (2)
	Psychologist (1)
Nursing Staff	Sisters (2)
	Charge Nurses (2)

Diagnostic Grouping: Acute disorders of all types. Limited selectivity.

4. The Northgate Clinic, West Hendon

A psychiatric clinic opened in 1968 as an extension to the services offered by West Hendon General Hospital. Autonomous management and independent medical policy making machinery, referred to as a 'therapeutic

community for the psychopathic assessment of adolescent boys, many of whom were criminals offenders and referred to the Clinic for psychiatric care. 25 beds, 24 staff, 14 of whom were interviewed.

Medical Personnel	Medical Director (Consultant Psychiatrist) (1)
	Consultant Psychiatrist (1)
	Registrar (1)
Administrative & Non-Medical Personnel	Nursing Officers (2)
	Clinical Psychologist (1)
	Social Workers (3)
	Occupational Therapist (1)
Nursing Staff	Staff Nurse (1)
	Assistant Nurses (3)

Diagnostic Grouping: Adolescent personality disorders.

5. Henderson Hospital, Surrey

One of the best known examples of a small hospital run as a 'total' 'therapeutic community', medically, and to a large extent managerially, independent of the neighbouring Belmont hospital to which it is still attached. Henderson serves a national catchment area, selecting its patients from referrals made by Courts, Local Authorities, other hospitals and medical group practices. Since the time of Dr. Maxwell Jones' involvement and the Rapoports study of the 'Social Rehabilitation Unit', Henderson hospital has retained its unique mode of intensive 'milieu therapy' in which interactional and confrontation procedures feature in contrast to the traditional 'passive patient' model of treatment.

35-40 staff of whom 20 were available for interviews, 40-60 patients both male and female. Bed complement, 100.

Medical Personnel	Consultant Psychiatrist (1)
	Registrars (2)
Administrative & Non-Medical Personnel	Asst. Chief Male Nurse (1)
	Asst. Matron (1)
	Psychologist (1)
	Social Workers (2)
	Occupational Therapists(1)
Nursing Staff	Sisters (3)
	Charge Nurses (3)
	Social Therapists (5)

Diagnostic Groupings: Sociopathic Personality Disorders.

6. Dingleton Hospital, Roxburghshire, Scotland

Dr. Maxwell Jones' famous hospital in the Scottish Borders run as a total 'therapeutic community' serving four counties and a catchment area of 100,000 population. Bed complement, 418; and 300 patients at time of interviewing. Interviewees were chosen according to availability from ten wards of the hospital. The notable achievement of this hospital has been the extension of the services of the hospital into the wider social community, thus limiting the number of referrals to hospital and fostering public support for community-based programmes of care.

Medical Personnel	Psychiatrist Administrator (Consultant Psychiatrist) (1)
	Registrars (3)
	Junior Doctors (2)
Administrative & Non-Medical Personnel	Secretary (1)
	Nursing Officers (2)
Nursing Staff	Charge Nurses (6)
	Sisters (3)

Nursing Staff (continued/...) Staff Nurses (4)

Student Nurses (2)

Assistant Nurses and Social Therapists (3)

Diagnostic Grouping: All patient groups given that the hospital is viewed as a 'total' therapeutic community.

From this selection of six hospitals and nine settings chosen for interview purposes, it can be seen that the term 'therapeutic community' is used to describe quite dissimilar modes of organisation although their functions and aims could be said to correspond to a 'general' approach to the treatment of psychiatric disorders.

Three of Muzekari's four organisational models of the therapeutic community can be used to exemplify the differences between the communities chosen for the present study. It will be remembered that he distinguishes between the therapeutic community as:-

(i) a total social organisation

(ii) a functional subsystem of a larger organisation

(iii) an autonomous, encapsulated organisational structure.[1]

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[1] Muzekari L.H. Op Cit 1970 pp.79-82 See also notes to Chapter 6 (44)

Diagramatically, the nine chosen settings can therefore be distinguished as follows:-

Figure 2

Theoretical Model	Corresponding Organisations
1. Total Social Organisation Administrative and Clinical Goals Congruent	Dingleton Hospital, Scotland Henderson Hospital, Surrey.
2. Functional Subsystem of Larger Organisation e.g. Ward, Wing, Building. Admin./Clinical collab essential.	Northgate Clinic, Middlesex Wards M1, N1, O1, Claybury Hospital, Essex. Hereward House, Fulborne Hosp. Cambridge.
3. Autonomous, Encapsulated organisational Structure Goals of community and larger organisation often incongruent e.g. Demonstration project.	Woodside Villa, Shenley Hosp. Herts. Villa 21, Shenley Hosp., Herts.

Forms of organisation of the type represented in Group 3 have the most difficulty in maintaining their individuality since the means by which these 'communities' attain their respective goals of 'therapeutic effectiveness' are often in conflict with the means and goals adhered to by the larger organisations of which they are a part. Descriptions in the literature of the problems encountered by hospitals in the process of adaptation from 'custodial' to 'therapeutic' forms of patient care would bear this point out.[1]

[1] See Chapters 5 & 6, Part 2.

(b) Respondant Groups

The composition of the total respondant group was initially influenced by problems of availability of staff for interviewing purposes. Moreover, from the start it was realised that inter-community comparisons of staff views would be extremely difficult owing to the variability in the size of each community's staff team. For example, it would be misleading to compare the views of the four nursing staff at Shenley's Villa 21 and at the Northgate Clinic when, in percentage terms, these numbers represent 80% and 29% respectively of both staff complements.

On the other hand, comparisons of the differences between the views of each professional group throughout the total respondant population was thought could provide a useful supportive body of information to that already deriving from an analysis of the total range of interviews. Two sets of data are, therefore, derived from the interviews:-

(i) the responses of all staff across all of the communities visited

(ii) the responses of different professional groups across all the communities visited, namely:

(a) medical personnel
(b) administrative and non-medical personnel
(c) nursing personnel.

It was expected, prior to interviewing, that the size of each of the professional groups would vary in accord with the distribution of such personnel throughout each psychiatric setting. It was not the intention of the researcher at this stage to attain equally-balanced numbers of doctors, administrative and non-medical, and nursing personnel, since in the normal work situation, for example, nurses will always exceed doctors and psychologists in number. Furthermore, if the

opinions of nursing staff are to be proportionately represented it seems obvious that they will form the largest of the respondant groups. The influence that this method of selection of interviewees had upon the composition of the respondant group as a whole can be shown diagramatically:-

Figure 3

Composition of Respondant Groups (Interview Numbers)

Hospital/Community	Medical Personnel		Non-Medical Personnel		Nursing Personnel		Totals
	No.	%	No.	%	No.	%	
Dingleton	6	(21.4)	3	(10.7)	19	(67.8)	28
Henderson	3	(15.0)	6	(30.0)	11	(55.0)	20
Claybury 01	3	(20.0)	3	(20.0)	9	(60.0)	15
Claybury M1	1	(7.0)	3	(21.4)	10	(71.4)	14
Claybury N1	1	(7.7)	4	(30.8)	8	(61.5)	13
Hereward House	2	(12.5)	4	(25.0)	10	(62.5)	16
Villa 21	1	(20.0)	0	-	4	(80.0)	5
Woodside Villa	1	(12.5)	3	(37.5)	4	(50.0)	8
Northgate Clinic	3	(21.4)	7	(50.0)	4	(28.6)	14
TOTALS	21	(15.78)	33	(24.81)	79	(59.39)	133

Of the 133 interviews carried out, 79 were with nursing staff, 33 with non-medical personnel and 21 with medical personnel, representing 59.4%, 24.8% and 15.8% of the total number respectively.

The decision to have only three respondant groups represented in the analysis of the data was prompted by an awareness that too many staff catagories would, in the final analysis, result in vague generalisations. The composition of the second group, 'administrative and non-medical personnel' is the only one of the three that presented any immediate

problems. In this group, psychologists, social workers, occupational therapists and administrative officers were all combined because it was felt that their roles were all in some way indirectly concerned with community life or centred upon the 'external' interests of the patients as distinct from their ongoing experiences in 'milieu therapy'.

Of a total of 133 respondants, 79 were male and 53 female. The nationalities of staff varied considerably: altogether 69 were British and 48 were from foreign countries. The composition of respondants by rank or status was as follows:-

Figure 4

Respondant Groups by Rank or Status	No. Interviewed	
Consultant Psychiatrists	8	Medical Personnel
Registrars/Senior Doctors	8	
Junior Doctors	4	
Admin. & Nursing Officers	11	Administrative and Non-Medical Personnel
Social Workers and Occupational Therapists	19	
Psychologists	3	
Charge Nurses	18	Nursing Personnel
Sisters	12	
Qualified RMN, SRN, SEN Nurses	22	
Student Nurses	15	
Nursing Assistants Social Therapists	13	
TOTAL	133	

5. Construction and Administration of Exploratory Interviews Schedule

Since the general aim of the interview schedule was to elicit responses from medical and non-medical staff workin in selected psychiatric settings concerning the meaning and utility of the concept of the therapeutic community, it was accepted from the start that the information collected would be normative in content and would involve the use of subjective methods of interpretation.

Owing to the confusion already surrounding a number of key issues concerning therapeutic community practice, many of the questions addressed to the interviewees were deliberately left open-ended so that the researcher could make some kind of assessment of the range of opinions that he would be likely to encounter both in the preliminary and latter stages of research.

(i) Administration

In every case, the interviewee was asked in advance to suggest an appropriate time, usually for up to one hour, in which he or she would be available to answer a series of questions about the nature, structure, functions and purpose of the 'therapeutic community' in the treatment of psychiatric disorders.

All interviews were conducted in private and an assurance was given that the names of the interviewees would be omitted from the schedule with only professional status being recorded as a means of identification. Following a few introductory remarks the researcher read out each question from the schedule and after each response briefly noted its content. In a number of cases this procedure was quite simple given that certain questions only required a 'yes' or a 'no' as an answer, whereas in others, answers needed to be recorded in sentence form.

Any uncertainty that was felt either by the interviewee or the interviewer was dealt with through informal exchanges of questions; in this way a relaxed atmosphere was generated and mor positive responses encouraged.

(ii) Construction

In its original form, the interview schedule was composed of 43 questions, each of which was designed to gather information from the respondants concerning ten areas of their experience and knowledge of 'therapeutic community' practice. During the course of preliminary discussions however, it was decided that some of these questions were either answered by other questions dealing with similar topics, or simply lacked sufficient clarity of meaning for their inclusion in the interviews to be justified. As a result, the number of questions that were used was reduced to 33.

It was further decided that in order not to replicate any respondants answers to questions on a similar topic, these questions should be spread throughout the interview. For example, the following could be interpreted to mean the same thing:-

(1) If you face any difficulties in your job that you think you might not experience in a more conventional setting, what kinds of things would these be?

(2) What kind of strains do you encounter in therapeutic community work?

In point of fact, the first question is concerned with general task-oriented problems as distinct from the second which is concerned more with personal feelings about involvement in emotionally demanding situations. Therefore, although both questions are evaluated under a

section heading entitled 'Role and Task Satisfaction', on the interview schedule they are separated from each other by five quite unrelated questions.

Altogether ten sections;comprise the interview:-

Section 1	General information about Interviewee
Section 2	Previous Experience
Section 3	Evaluation of Work Setting
Section 4	Treatment preferences/orientation
Section 5	Criteria of Definition of Therapeutic Community
Section 6	Effectiveness of Therapeutic Community Methods
Section 7	Operative Treatment Processes
Section 8	Patient and Staff Selection in the Therapeutic Community
Section 9	Role and Task Satisfaction
Section 10	Institutionalisation

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CHAPTER 8

THE FINDINGS OF THE PILOT STUDY

Analysis of Interview Data*

Post-interview content analysis of open-ended data presents a number of methodological difficulties, one of which relates to the procedure adopted for grouping or coding information. It was necessary to adopt a simple method whereby qualitative information could be quantified without the meanings implicit in the data becoming obscured. If one accepts that the character of the categories selected will depend upon the researcher's specific interests it becomes possible to predetermine the kinds of criteria which can be used to assess the data in the course of transcript analysis. In other words; if the researcher has in mind the kinds of answers that he thinks he may get to certain questions and can represent these through relevant headings during the process of coding, the task of quantifying qualitative data becomes much easier. By adopting this kind of procedure the researcher is able to extract "a series of empirically anchored scores that transform the elusive free flow of communication into statistically manageable units".[1]

Section 1. General Information

Apart from the obvious questions concerning date and place of interview, sex and professional status, most of which is referred to in the sections above describing the characteristics of the respondant groups, the interviewees ages and length of service in their present hospitals was

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[1] Millon T., Diesenhaus H.I. Op Cit pp.98-101

* For an assessment of the complete Interview Schedule see the Appendix to Chapter 7, pp. 363-369

requested because it was thought that they might influence the kinds of answers that would be given to later questions. The left hand column of the following diagram shows the respondant groups ranked by average age, flanked on the right by (i) the average length of service of each group, and (ii) range of years in service:-

Figure 5

Composition of Interview Sample

Professional Status	Average Age (yrs.)	Average Length of Service (yrs)	Range (yrs)
Consultant Psychiatrists	47	8	3-18
Administrative Staff	41	11	0.75-25
Registrars (Medical)	39	1 - 3	0.75-5
Junior Doctors	38.8	2.8	0.75-8
Charge Nurses	37	11	0.75-26.5
Sisters	37	10	1-14
Psychologists	35	2	0.75-8
Social Workers & Occupat. Therapists.	29	1	0.25-3
Qualified Nurses	26	2	0.08-8
Student Nurses	25	1.25	0.4-4
Soc. Therapists/Assist.	25	0.75	0.08-3

Although, by themselves, these figures tell us very little, it is nevertheless worth noting that administrative and senior nursing staff (charge nurses and sisters) have, on average, spent longer periods of time in the unit or hospital in which they were interviewed than any of the other groups which lends weight to the view that such staff not only play a major role in the establishment of therapeutic community methods and goals but are probably the main carriers of therapeutic community

culture as well.

Section 2* Previous Experience

In order to assess the kinds of psychiatric experience that staff had undergone prior to their current employments, two questions were addressed to all interviewees:-

1. Have your previously worked in a mental hospital?
2. How would you describe the type of treatment regime in operation there?

1) In response to the first question it was found that 63% of all staff had experience of other mental hospitals, although, as one would expect, the most junior nursing staff had the least experience of all the respondants. (Student nurses 20%, Social Therapists, Assistant Nurses 30%). Nursing sisters showed a surprising lack of earlier experience, perhaps accounted for by the fact that many of these nurses lived and trained locally and, therefore, tended to stay with one hospital for considerable periods of time.

2) The answers to this question fall into three main groupings; Hospital treatment regimes were described as:-

(i) Traditional, custodial or physical

(ii) Therapeutic community 'type'

(iii) Eclectic

Only 9% of the total sample claimed to have had experience of 'therapeutic community' methods prior to their current work, compared with 32% who described these other hospitals as 'traditional' or 'custodial', and 59% who described them as 'eclectic' in orientation. It is interesting that in most cases, staff seemed to accept that 'traditional' methods and 'therapeutic community' methods were polar

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* All data relating to Sections 2-10 can be found in relevant tables in Appendix to Chapter 8, pp 370-396.

types of treatment orientation with 'eclectic' methods somewhere between the two, representing a kind of compromise between the 'old' and the 'new' approaches.

Section 3. Assessment of Current Work Setting

Two questions were addressed to the interviewees concerning the nature of the treatment approaches in their communities.

1. Is the Unit (hospital , ward, wing etc) in which you are at present working any (a) more progressive, (b) less progressive than that in which you were previously working, or is it (c) much the same? (d) No former employment/other.

Since all of the settings chosen for interview purposes had been selected on the grounds that they all used the term 'therapeutic community' to describe their general treatment organisation it was expected that staff would answer the above question by choosing (a), because it was thought that this would reflect the prevailing attitude towards 'liberal' psychiatric methods of treatment. The data in fact supports this expectation:

85% of the total interview sample felt that the communities in which they were currently working were more progressive than other settings in which they had worked previously, compared with 3% who thought they were 'less progressive', 6% who thought they were 'much the same' and 7% who either had no former experience or gave a quite different answer. The responses to this question appear uniform throughout all the professional groups.

2. Types or methods of treatment currently being used in this hospital

In this question, respondants were asked to state which kinds of treatment, or comment upon the nature of the treatment approach, currently being practiced in their communities. Examples such as physical

therapies, psychotherapies, therapeutic community approach were given in order to minimise the number of diffuse categories that could have resulted from general answers.

The findings were as follows:-

69% of the total interview sample described the treatment approach of their Unit as a 'therapeutic community orientation'.

15% described treatment methods as eclectic.

13% itemised Group Psychotherapy as the main treatment method.

5% described individual psychotherapy as the main treatment method.

4% described the treatment approach as 'physical' in orientation.

2% gave other answers.

What is most noticeable on examination of the differences in choice between the professional groups is that the least senior staff members show the greatest unqualified support for therapeutic community treatment orientations. Of the nine hospital Communities visited, practically all of them could be described as utilising a number of different therapeutic techniques and yet the term 'therapeutic community' is most often used to cover all of them. It would seem reasonable to suggest therefore, that one of Jones' central principles of therapeutic community treatment - that all aspects of community life play an essential role in treatment - has become widely accepted by staff working in 'therapeutic community' settings, even though many of them may be unaware that this is the case.

Section 4. Treatment Preferences and Orientations

The aims of the two questions in this section were to discover whether (a) the term therapeutic community was generally applicable to a range of treatment approaches and (b) whether the use of therapeutic community methods in mental hospitals could be said to represent 'progress' in psychiatric practice.

1. Do you have a preference for any particular mode of treatment or treatment orientation?

The range of answers to this question varied considerably, but included (a) Milieu Therapy (b) Therapeutic Community (c) Group and Individual Psychotherapy (d) Physical treatments (e) psychodynamic approaches (f) eclectic approaches and (g) 'don't know'.

When split up into percentages, preferences throughout the sample for any one of these treatment approaches were as follows:-

Group Psychotherapy	28%
Eclectic Approach	25%
Therapeutic Community	25%
Psychodynamic Approaches	5%
Milieu Therapy	5%

Less than 1% expressed a preference for the use of physical or mechanical therapies.

Medical staff show a more discerning view of methods of treatment than do the other professional groups and as a body they could be said to prefer an open or 'eclectic' approach to treatment. Non-medical, and nursing staff show an above average preference for the use of group therapy techniques (both 26%) and administrative personnel show a similar preference towards the use of therapeutic community methods.

It is interesting to note that 67% of the nursing sisters interviewed, along with 40% of student nurses and 42% of social workers and occupational therapists showed a general preference for the use of group therapy techniques whilst the average for the whole sample was only 28%. This would suggest that considerable modifications to the traditional roles of, in particular, nursing staff, has taken place since the introduction of psychodynamic methods of treatment and

emphasises the participatory value of these staff to treatment programmes.

On the other hand, it is to be expected that a greater emphasis would be placed upon group psychotherapy than other methods of treatment, given that all staff interviewed already worked in communities utilising these methods.

2. Would you equate the use of therapeutic community methods in mental hospitals with 'progress' in psychiatric practice?

This question required only a 'yes' or a 'no'. 84% of staff interviewed, answered 'yes', and 16% 'no'. Answers were once again uniform throughout all the professional groups.

Although it might seem a truism to say that therapeutic community methods are indicative of progress in psychiatry, it is nevertheless the case that in the past such a view has been based largely upon the minority opinions of doctors who have recorded successes in this field of work and not upon the general consensus of views deriving from their supporting staff. Even though the above question requires only the most basic of answers it does at least tell us that staff at all levels of the hospital hierarchy agree with the propositions that therapeutic community methods are 'progressive'.

Section 5. Therapeutic Community: Criteria of Definition

The four questions contained within this section were designed to evoke responses concerning (i) the main characteristics of therapeutic community methods of treatment (ii) scale of communities (iii) some of the factors underlying definitions of therapeutic community practice, and (iv) 'untherapeutic' features of therapeutic communities.

1. What would you describe as the central features of 'therapeutic community' methods of treatment?

It was expected that a number of varied answers would be given to this question and that they would be difficult to clarify, however, the data turned out to be less confusing than was first thought. The features that were said to underpin the therapeutic community and the preferences shown for them, are represented as follows:-

1.	Democratic process	23%
2.	Communal responsibility	20%
3.	Crisis resolution methods	15%
4.	The total therapeutic milieu	15%
5.	Permissive atmosphere	13%
6.	Psychotherapy	7%
7.	Composition of the Staff	2%
8.	Don't know	7%
9.	Other	0.5%

The most noticeable feature of this range of responses is the inclusion of (i) democratic process (ii) communal responsibility (iii) crisis resolution methods and a (v) permissive milieu, not because one would expect these features to be common to all therapeutic communities, but because they seem to reflect the Rapoport's findings in their study of Maxwell Jones' Social Rehabilitation Unit at Belmont Hospital.[1] It will be remembered from the discussion of their work in Part 2 that they outlined four 'operative treatment processes'. These were described as (i) Democratisation (ii) Permisiveness (iii) Communalism and (iv) Reality Confrontation. The relationship

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[1] Rapoport R.N. & R. Community as Doctor: New Perspectives on a Therapeutic Community. Tavistock 1960.

between the responses of those interviewed and these four theoretical process categories is quite marked. It perhaps reflects the long-term influence that this analysis of a therapeutic community has had upon the development of ideas in other communities. It is accepted that the researcher was subject to the same influence during the examination of the interview data and perhaps tended to interpret some of the answers in terms of these categories.

2. <u>On what scale do you think that a therapeutic community can best function?</u>

As Muzekari[1] has recently pointed out, therapeutic communities tend to be all kinds of sizes and all forms of organisation, therefore, it seemed reasonable to ask members of hospital staff to describe the kind of size and scale through which a community could best function.

Answers to this question fell into three main groups:-

A therapeutic community would function best as a

1. total hospital organisation
2. autonomous or external unit
3. internally independent, though externally regulated ward or unit.

Preference for each of these modes of organisation were as follows:- (% of total interview sample)

1. Autonomous, external unit	41%
2. Internally independent ward	36%
3. Total hospital	23%

In terms of patient numbers in any community, the range was very large, (6-600) which reflects the variations between the three different modes of organisation mentioned above. However, a more familiar

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[1] Muzekari L.H. Op Cit 1970

small-unit size emerged when a median figure of 23.5 was calculated.

The reasons for the different preferences of size and scale vary to some degree between the professional groups. Medical staff tended to feel that smaller therapeutic units make for better staff-patient rapport in therapy, but it was also felt that small units function even more effectively when they are supported by a sympathetic administration in the hospital to which they belong.

Administrative and Non-Medical personnel tended to emphasise organisational advantages of smaller units particularly in the sense that decentralisation of hospital wards helps to improve team work and makes administration an easier task. Nursing staff felt that small units offer a more realistic therapeutic environment and help to improve interpersonal relationships. In a few cases it was argued that a hospital run as a 'total' therapeutic community could help to avoid problems arising from 'preferential' treatments being given in special wards or units.

3. The aims of the therapeutic community are often described as being generally agreed upon, however, the means by which these aims are achieved vary considerably between hospitals. This has led to uncertainty about the contribution that therapeutic community methods can make to psychiatry. Would you agree or disagree with the following propositions:

That this situation may have arisen because:-

(a) Therapeutic community methods and aims are ill-defined.

(b) Mental disorders cannot be effectively treated by these methods.

(c) Formal medical and nursing training is inappropriate for work in a therapeutic community.

(d) Milieu therapy has always to be supplemented by more traditional methods of treatment (e.g. drugs, ECT).

(e) Everyone's conception of what is 'therapeutic' in a community, differs.

Each one of these propositions originated out of discussions with hospital personnel and from remarks in the literature about the utility of therapeutic community methods.

Analysis of the answers to these five main propositions showed that:-

(a) 71% agreed that therapeutic community methods and aims were poorly defined. 29% disagreed.

(b) 99% disagreed that mental disorders cannot be treated by means of these methods. 1% agreed.

(c) 89% agreed that medical and nursing training is often inappropriate for work in a therapeutic community. 11% disagreed.

(d) 59% agreed that milieu therapy methods have to be supplemented by more conventional methods of treatment. 41% disagreed.

(e) 86% agreed that everyones conception of what is 'therapeutic' in a community differs. 14% disagreed.

The picture that emerges from these findings is one of acceptance of the utility of these methods but uncertainty about their status in comparison to other approaches. There is little doubt that in the minds of most staff the concept of the therapeutic community is vague yet provides a source of inspiration to those who are concerned to move away from the more conventional, custodial approach to patient care.

4. Which, (if any) of the features of your community do you think are not therapeutic for the patients?

114 out of 133 of those interviewed answered this question. Nine

groups of factors were cited as 'untherapeutic' features of these therapeutic communities:-

Figure 6

Rank Order	Features Identified	Number of Staff who mentioned them
1	Lack of definition of aims/goals; structural inconsistency.	31
2	Problems in authority/discipline/staff inconsistencies.	29
3	Communication problems/problems of responsibility, permissiveness.	17
4	Different interpretations of value/ function/nature of psychotherapy.	12
5	Relationship problems between staff and patients.	11
6	Differences in interpretation of value/ functions of meetings.	6
7	Usage of 'traditional' treatment methods e.g. ECT, drugs.	6
8	The encouragement of a new kind of patient dependency.	1
9	Dissatisfaction with scope of activities offered.	1
	TOTAL	114

Nursing staff expressed most dissatisfaction over questions of authority and discipline (19) perhaps reflecting the often ambiguous position in which they are required to work. On the one hand they are trained to respect authority and to maintain a discipline in which patients and staff retain a formal distance from each other, whereas on the other hand, in a therapeutic community, they are called upon to participate fully in decision making and in the assessment of the day-to-day life of the

community. It is, therefore, not always clear to the nurse where pyramidial authority gives way to communal decision-making and joint responsibility.

The fact that the most oft-quoted 'untherapeutic' feature of the therapeutic community was the lack of definition of aims and general goals provides further support for views expressed in the literature concerning the confused nature of the therapeutic community concept, and complements the findings of the previous question in which 71% of staff agreed that therapeutic community aims were poorly defined.

Section 6. Effectiveness of Therapeutic Community Methods

The four questions in this section concentrate upon (i) rehabilitation and the therapeutic community (ii) criteria of success in treatment and (iii) the future of community therapy techniques.

In the past, comparisons of therapeutic community methods with custodial forms of care have contributed towards a belief in the 'rehabilitative' potential of the former. Staff were, therefore, asked to comment upon the following two propositions:-

1. It could be said that one of the main functions of therapeutic community treatment is to get the disordered individual back into the wider community as soon as possible and with the minimum of distress. How real do you think this proposition is?

72% of staff interviewed thought that this was a realistic proposal, whereas 28% did not.

In the light of Maxwell Jones' work in which 'treatment' and 'rehabilitation' enterprises are intimately linked in an expression of a total reorientation process it could be argued that 'getting the individual back into the wider community' is the general aim of any enlightened psychiatric community and hence to argue that it is a

realistic proposal is to say very little about the real questions concerning the effectiveness of a community's treatment programme.

2. In your estimation, can therapeutic communities be any more successful in rehabilitating patients than other treatment approaches?

Like the last question this too could be interpreted in different ways. It was expected that staff would understand the general intention behind it and answer simply with a 'yes', 'no' or 'don't know'. In fact, 79% answered 'yes' compared with 18% who said no, and 7% who said they didn't know.

Even if these answers do not tell us anything about the rehabilitation process they nevertheless point to a considerable degree of optimism inherent in therapeutic community work. 'Faith' in the theory and practice of this approach to treatment becomes more evident as one proceeds with the general questioning of staff about their involvement in treatment.

3. How would you define 'effectiveness' in terms of therapeutic community success?

The purpose of this question was to assess the range of criteria used by staff to define 'success' in treatment since it was felt that no clear statement of views at present exists. Responses to the question were extremely varied, but can be compressed into three main groups, namely:-

1. Patient-oriented criteria
2. Staff-oriented criteria
3. Externally oriented criteria.

These comprise the following responses:-

1. Patient-oriented criteria When a patient.....

(i) expresses an opinion of how the community has helped/him/her

(ii) shows an increased awareness of choice and of problems

(iii) feels a personal sense of achievement and can assess own progress,

(iv) shows signs of being able to cope and live with problems,

(v) shows an improved ability to make adequate relationships with others,

(vi) shows signs of overcoming dependency on the community.

2. Staff-oriented criteria When members of staff.....

(i) observe changes/improvements in patient behaviour and morale,

(ii) can assess a patient's ability to cope, having reached an 'optimum' level of functioning,

(iii) communally agree that a patient's behaviour is improving,

(iv) particularly doctors/therapists, observe loss of 'presenting symptoms'.

3. Externally oriented criteria When it is felt that.....

(i) a patient is expressing a genuine desire to leave hospital,

(ii) a patient could hold down a job,

(iii) a patient has proven that he/she has established a permanent life-style in the outside community,

(iv) discharge or readmission statistics show an improving trend

(v) a patient has successfully returned to his/her former life style.

Out of a total of 132 responses:-

39% defined effectiveness/success in the terms expressed in group 1 (patient-oriented criteria); that is, it was seen as a subjective capacity of the patient to gain insight and to improve the range of choices open to him/her in a therapeutic community.

36% defined success in the terms expressed in group 3 (externally-oriented criteria) that is, as a proof of being able to get back into the outside community, or breaking away from the hospital.

23% defined success in the terms expressed in group 2, (Staff-oriented criteria) that is through the staff evaluation of changes in patient behaviour, diagnosis or symptoms.

2% didn't know or didn't comment.

The first thing that strikes one on examination of these responses is the 'evaluative' or 'subjective' manner in which they are described. Conventional techniques of assessing 'success rates' have always depended upon discharge and readmission statistics or marked changes in presenting symptomatology. From this point of view, therefore, ways of evaluating 'therapeutic effectiveness' in a therapeutic community differ markedly from those previously in vogue.

Since some of the main principles of therapeutic community life concern 'democratic' decision making, joint discussion and 'feedback', it is significant to learn that these are utilised in the assessment of 'success' and 'effectiveness'.

Instead of viewing the patient who leaves hospital as a statistic, the evaluative method notes the smaller, often less significantly obvious changes taking place in the experience of the patient as a member of a community.

4. Do you see 'Community Therapy' (both in and outside the hospital) as an answer to future problems of mental disorder?

Although 67% of the respondants answered 'yes' to this question and 16% said 'no', a further 17% thought that "Community therapy', in whichever form it takes, is only a partial solution to questions of the treatment of mental disorders.

Within the professional groups, 71% of the medical personnel favoured community therapy techniques with only 5% showing a clear lack of enthusiasm for their future potential. In comparison with the

administrative and non-medical group of whom 21% showed a similar lack of enthusiasm, and the nursing personnel, 17% of whom also showed similar negative responses, the medical group, it could be argued, have a tendency to put greater faith in the use of these methods than their supporting staff.

Section 7. Operative Treatment Processes

The above phrase derives from the Rapoport's use of the four processes underlying the treatment approach adopted at the Social Rehabilitation Unit, Belmont Hospital during the late 1950's; which were (i) Democratisation (ii) Communalism (iii) Reality confrontation and (iv) Permissiveness. Since these terms have tended to become part of the working language of therapeutic community staff, despite their different interpretations, it was decided that interviewees should be questioned on three of these processes, in order to establish whether or not they have a general application to differently styled communities.

1. Democratization

Do you think that all members of the community can share equally in therapeutic and administrative decision-making?

Out of a total of 129 responses to this question, 85 (66%) answered 'yes' and 44 (44%) 'no', underlining the general support for a democratically-based decision making procedure within therapeutic communities, despite the fairly large minority opinion against such a procedure.

2. Permissiveness

To what extent do you think that staff should tolerate acting-out behaviour in the community?

The range of answers to this question was large, but they have been compressed into eight groups which are as follows:- (The figures to the

right of each answer represent percentages of the total number of responses).

1. To the point where it becomes intolerable or damaging to the community. (41%)
2. Until it becomes evident that it might further damage the patient. (13%)
3. Until it becomes intolerable to the staff. (9%)
4. No limitations should be set. (14%)
5. It should not be tolerated at all. (14%)
6. Proper controls should be maintained at all times. (8%)
7. It should be ignored completely. (1.5%)
8. Other answers/Don't know. (2.2%)

By far the largest group of respondants - 41% (54 out of 132) considered that acting-out behaviour should be tolerated to the point where it becomes clear that it is likely to damage the community in some way. This would suggest that a considerable degree of permissiveness exists within these communities before decisions have to be taken about the behaviour of a patient. There is no easy way in which to guage the tolerance threshold of any community, however, these results seem to reinforce the view that communal responsibility for the welfare of patients undergoing periods of acute disturbance, is preferable to any of the other alternatives given by staff.

3. Communalism

Are the following features essential to a therapeutic community?

(i) Informal use of christian names between patients and staff.

(ii) General sharing of amenities.

(iii) Frank expression of thoughts and feelings.

(iv) Communal staff-patient decision making.

Differences of opinion over these four features of community policy

have been expressed in the literature and, therefore, it seemed appropriate to find out to what extent they are accepted in the communities visited. It turned out that staff were almost unanimous in their support for all four features. The results were as follows:-

1. 93% of the sample agreed with the informal use of christian names. 7% disagreed.
2. 92% of the sample agreed that amenities should be shared. 8% disagreed.
3. 90% of the sample felt that frank expression of thoughts and feelings was essential. 10% disagreed.
4. 75% - the smallest proportion - agreed that joint staff-patient decision making was essential in a therapeutic community. 25% disagreed.

If it is at all possible to generalise from the findings in section 7, it seems that 'democratisation', 'permissiveness' and 'communalism', are open to interpretation by the members of the different communities[2] and tend to be treated as sufficient but not necessary conditions of therapeutic community life. The degree to which communities may differ in their expression of communal responsibility, democratic participation and permissive attitudes, depends upon intrinsic factors such as the nature of the patient population, the influence of external controls and the flexibility of staff attitudes towards change and innovation.

There is a tendency in the literature to assume that these processes are <u>necessary</u> to any therapeutic community. The problem with this is that too much attention is focussed upon showing how democratic or permissive a milieu can be, and too little upon the kinds of variation to be found in the applications of these ideas to psychiatric settings. As was mentioned in the previous chapter, it may be that the credibility of a therapeutic community is partially determined by the ability of its

staff to provide an adequate justification for the creation of a democratic-permissive milieu.

Section 8. Patient and Staff Selection in the Therapeutic Community

Considerable interest has been expressed in the literature over the question of which disorders respond 'best' to treatment in a therapeutic community milieu. It is often stated, for example, that 'schizophrenic' disorders respond least well to this kind of milieu therapy because the patient's responsibility for his own behaviour is limited and hence his ability to represent himself as a member of a democratic community is similarly affected.

It was, therefore, decided that staff would be asked three questions on these topics to establish whether any particular 'types' of disorder were considered more responsive to these methods. The expectation here was that, in the tradition of the early neurosis clinics of Jones and others, staff would tend to select the 'neurotic and personality disorders' as being most suitable to milieu therapy methods of treatment.

The second group of questions concern the selection of staff for work in therapeutic communities and are aimed at establishing some of the criteria used in methods of selection.

1. In your opinion would different types of disorders respond equally as well to treatment in a therapeutic community milieu?

Out of a total of 130 respondants, 77 (59%) answered 'no', whereas 49 (35%) said 'yes', and 4 (3%) did not know. Clearly some kind of selection procedure for involvement in a therapeutic community is deemed necessary by staff.

2. What methods of treatment do you consider would best suit patient disorders diagnosed as follows:-

(i) endogenous depression (ii) psychopathy (iii) schizophrenic type (iv) personality disorders.

The four diagnostic types were chosen because they appeared to be mentioned most often in the literature referring to therapeutic community treatment methods.

Six main treatment modalities can be identified from the total range of responses to this question:-

1. Therapeutic community methods.
2. Group therapies.
3. Eclectic procedures.
4. Physical therapies.
5. Individual therapies.
6. Outpatient treatments.
7. (Don't know).

Taking each diagnostic group individually, the results were as follows:-

(a) Endogenous depression (132 responses)	Number of Responses	Percentage of Total Responses
1. Therapeutic community methods.	37	28
2. Group therapies.	25	19
3. Eclectic procedures.	24	18
4. Physical therapies.	22	17
5. Don't know.	14	11
6. Individual therapies.	9	7
7. Outpatient treatments.	3	1

(b) Psychopathy (129 responses)	Number of Responses	Percentage of Total Responses
1. Therapeutic community methods.	50	39
2. Don't know.	31	24
3. Group therapies.	19	15
4. Individual therapies.	9	7
5. Eclectic procedures.	8	6
6. Outpatient treatments.	7	5
7. Physical therapies.	5	4
(c) Schizophrenic Disorders (133 responses)		
1. Therapeutic community methods.	45	34
2. Physical therapies	31	23
3. Eclectic procedures	19	14
4. Don't know	18	13
5. Group therapies	13	10
6. Individual therapies	4	3
7. Outpatient treatments.	1	0.8
(d) General personality disorders (116 responses)		
1. Therapeutic community methods.	58	50
2. Group therapies.	25	21
3. Don't know	22	19
4. Individual therapies.) 5. Eclectic procedures) 6. Outpatient treatments)	7	6
7. Physical therapies.	4	3

The choice of therapeutic community methods as the first preference

in the treatment of the four disorder types must be seen to reflect the fact that all staff interviewed were already working in therapeutic communities and, therefore, were predisposed towards this orientation. However, it would seem likely that the term is used in 'blanket form' to describe a general approach to treatment as distinct from a method or technique. For example, different treatment methods are often used within a general therapeutic community framework which includes group therapies and physical treatments. This is illustrated in the case of (c) Schizophrenic disorders in which a therapeutic community approach holds preference over physical or group therapeutic techniques, and why in the case of (b), psychopathy, 24% of the respondants (31) said that they did not know what treatments would suit this type of disorder and yet 39% (50) suggested that therapeutic community methods were preferable to all the others.

It is also interesting to note that 50% (58) of the respondants suggested that general personality disorders would respond most favourably to treatment in a therapeutic community. These findings substantiate earlier expectations. Furthermore, it is surprising to find that 34% (45) favoured this mode of treatment over other methods in the treatment of schizophrenic disorders. This finding is of considerable interest since it points to the general widening of the concept of the therapeutic community to include the treatment of psychosis. Further reference will be made to the question of treating mixed diagnostic groups in a therapeutic community in the chapter on research findings at Woodside Villa, Shenley Hospital.

3. <u>What type of disorder do you think best responds to treatment in a therapeutic community milieu</u>?

Answers to this question can be separated into six groups:-

1. Personality disorders
2. Psychopathic disorder
3. Psychoneurotic conditions
4. Schizophrenic states
5. Institutional neurosis and functional geriatric disorder
6. All conditions regardless of diagnosis

Expressed in percentages, responses were distributed as follows:-

39% thought that 'personality disorder' would respond best to this form of treatment, followed by

19% who thought 'psychoneurotic' conditions would respond best,

14% who felt that all psychiatric conditions could be treated in a therapeutic community setting,

11% either did not know, or were unsure of the diagnostic categories,

8% who felt that 'schizophrenic' disorders would respond best to this form of treatment,

7% who thought that 'psychopathic' disorders respond best, and

2% who felt that psychogeriatric conditions would respond best to the therapeutic community approach.

As expected, the largest percentage of responses to this question supported the view that 'personality disorders' respond best to treatment in a therapeutic community setting.

4. (a) Should staff be specially selected for work in a therapeutic community?

(b) Does this work involve special skills or personality attributes?

If it is true that involvement in a therapeutic community requires considerable modifications to the roles and attitudes of staff, then should there be some process whereby staff members are pre-selected on the grounds of offering special skills or a suitable temperament? When

these questions were asked, 81% of the respondants felt that staff should be specially selected compared with 19% who did not.

Of those that felt that such work required special skills or a certain kind of temperament;

43% (57) said that special attributes of personality were required whereas only 3% (4) felt that special skills or training were alone the most important factor in such work. On the other hand, 33% (44) felt that a combination of special skills and a sympathetic kind of temperament were essential to this kind of work. 21% (28) said that they did not know what was needed or felt that quite different criteria of definition of tasks and responsibilities needed to be employed.

Section 9. Role and Task Satisfaction

The four questions contained within this section were intended to assess the kinds of problems that staff members face when they are asked to adjust their work roles to suit the environment of a therapeutic community:-

1. Do you feel that you can fulfil your role as well in a therapeutic community as you might in a more conventional setting?

In answer to this question, 84% (112) said 'yes' of which 34% (46) claimed to be able to work better in such settings. Only 13% (18) said 'no', of whom non-medical personnel (administrators, social workers, occupational therapists and psychologists) expressed most difficulty in adapting to the different role demands.

Only one person said that no comparison could be made between the two kinds of role demands, and two others said that they did not know whether they could compare roles owing to lack of experience.

Two conclusions can be drawn from these findings. The first concerns

the obvious support for therapeutic community methods as potentially satisfying work situations for all levels of staff, whereas the second concerns the 'faith' that many staff have in the use of these methods despite the fact that a large number of them have no previous experience with which to compare them.

After all, in the section on general information at the beginning of this chapter it was shown that only 64% of the total sample (79) had had previous experience of other mental hospitals or psychiatric settings whereas in answer to this question, 84% (112) out of a total of 133 interviewees state clearly that they can work as well, if not better, in a therapeutic community as they would in a conventional setting.

2. If you face any difficulties in your job that you think you would not face in a more conventional setting, what kinds of things would these be?

1. Feelings of exposure, vulnerability to criticism and increased personal responsibility. Characteristic replies included (a) loss of authority resulting in feelings of vulnerability and insecurity (b) exposure to attack and criticism (c) responsibility for one's own actions (d) emotional stress.

2. Fears, Suspicions and hidden pathology of staff. Characteristic replies: (a) fear of acting autocratically, traditionally, i.e. in an 'authoritarian' manner, (b) suspiciousness of patient's motives and feelings (c) awareness of the hidden psychopathology of staff becoming exposed.

3. Role and Goal Confusion, Administrative and Practical problems. Characteristic replies: (a) confusion deriving from the lack of fit between training and practical responsibilities (b) absence of criteria enabling staff to judge the success of 'treatment' (c) lack of definition of overall goals and aims.

4. No problems/No comparisons/question inapplicable to present situation.

52% (68) of the sample expressed difficulties of the kind mentioned in group 1 which concerns feelings of exposure and vulnerability.
24% (31) expressed difficulties of the kind mentioned in group 3 concerning role and goal confusion.
18% (33) said they either experienced no difficulties in their jobs or could not compare therapeutic community work tasks with those associated with conventional psychiatric roles (Group 4).
7% (9) expressed difficulties of the kind mentioned in group 2 concerning fears, suspicions etc.

Nursing personnel expressed the most difficulty in Group 1 (44 out of 78) although the three professional groups show similar percentage totals overall. It is significant that only 18% of all those interviewed claimed to experience no difficulty in adapting to the demands of therapeutic community involvement, for the remaining 82% provide a useful picture of the kinds of conflicting role demands and problems that staff members, regardless of rank or status, face in the task of creating a milieu in which authority and privelage have to give way very often to communal responsibility, joint decision making and egalitarian aims.

3. What kind of strains do you encounter in therapeutic community work?

This question was originally designed to complement the one just described and was more concerned with personal stresses than practical difficulties. As it turned out, interviewees tended to interpret both questions in a similar manner despite the fact that they were separated on the interview schedule.

Six kinds of reply to this question were recorded:-

1. Emotional strains
2. Role strains; problems deriving from loss of authority
3. Threats to physical welfare of staff
4. Strain arising from confusion over aims and goals
5. None
6. Other answers

58% (78) mentioned emotional stresses encountered in this kind of work.
22% (29) mentioned role strain and authority problems.
10% (13) mentioned stress deriving from confusion over aims and goals.
6% (8) said they experienced no strains in this kind of work, and
2% (3) gave other unrelated answers to this question.

As in the case of the previous question it is clear that a majority of staff experience personal anxiety owing to the loss of traditional authority and the need to remain open to criticism. Medical personnel expressed the greatest sense of emotional strain (71% or 15 out of 21) probably due to the fact that they still retain overall responsibility for the running of a community and yet at the same time are expected to accept the decisions of the Community Councils or decision making bodies. On a number of occasions during the course of informal conversations with doctors, the researcher was made aware of the often contradictory demands made upon them by staff and patients on the one hand and hospital administrative personnel on the other.

4. Would you say that democratic participation of staff in a therapeutic serves to undermine their authority?

In answer to this question 51% (68) thought that 'authority' was not undermined by democratic participation compared with 40% who thought that it was. It must be added, however, that many of those who chose

to answer 'yes' also said that it did not matter whether authority was undermined, preferring to view it instead as a positive state of affairs.

When viewed in conjunction with the other question responses in this section, it is clear that therapeutic community personnel recognise the importance of democratic participation despite the anxiety that is produced as a result of it. The need to adapt to a different style of working throws into relief the kinds of contradictory demands that are made upon staff who are trained to accept an heirarchical authority structure.

Section 10. Institutionalisation and Chronicity

It is widely held that 'milieu therapy' treatments are only successful in the treatment of acute disorders and that therapeutic community methods are inappropriate to the care and treatment of chronically disturbed patients many of whom may be suffering from the secondary effects of neglect and 'institutional-neurosis'. There are, however, some notable examples of the use of therapeutic community techniques in the remotivation of institutionalised patients.[1] Since this seemed to be one of the more uncertain areas of opinion (along with the question of treating patients undergoing 'psychotic' breakdown) it was decided that staff would be asked about their opinions concerning chronicity and institutionalisation. Three questions were advanced:-

1. Would you say that many of the older, 'long-stay' patients in mental hospitals stand little chance of being rehabilitated into the wider community?

Out of a total of 103 responses:-

81% (83) of the sample said that they thought such patients would remain in hospital indefinitely, whereas 11% thought that there was a possibility

[1] Maller J.O. The Therapeutic Community with Chronic Mental Patients. Bibliotheca Psychiatrica No.1461. S. Karger A.G. Basel 1971 & Refs. to Chapter 6, Part 3 under 'Uses of the term Therapeutic Community' Nos. 27-9.

that 'chronic' patients could be rehabilitated. A slightly larger percentage (13%) gave different, unrelated answers.

This finding would reflect the situation that has existed in mental hospitals up until very recently, whereby those patients who became subject to earlier, less enlightened forms of treatment or custody stand little chance of being able to support themselves either within or outside hospital.

2. Do you think that 'longer stay' or 'chronically' disturbed patients can benefit from treatment in a therapeutic community?

Out of a total of 132 responses:-

63% thought that these patients can benefit from this treatment, 26% thought that these patients do not benefit from this treatment and 11% said that they did not know.

Comparisons between the responses of the professional groups shows that medical staff and non-medical professionals have a tendency to support the use of therapeutic community techniques in the treatment of 'chronic' disorders (76% and 71% respectively) whereas nursing staff, despite a majority of opinion in favour of these techniques (56% or 45 out of 80) still show a more conventional attitude towards the care of these patients. (34% or 27 out of 80).

3. Do you think that involvement in a therapeutic community can help a patient to overcome the effects of institutionalisation?

Out of a total of 133 responses:-

82% (109) said that such involvement could help to overcome the effects of institutionalisation. 13% (17) did not think that it could and 5% (7) either did not know or gave unrelated answers.

A comparison of these findings with those of the previous two questions would suggest that a strong belief in the potential of therapeutic community methods exists even though many older patients may not be given the opportunity to experience them.

Summary and Conclusions

One of the first things that becomes apparent on reviewing these findings is the sense of optimism that seems to pervade staff attitudes towards therapeutic community ideas and methods. When one remembers that the 'milieu therapy' movement originated out of a reaction to custodial practices and has tended to emphasise not only the possibility of re-activating and stimulating patients, but also their involvement in the treatment process it seems reasonable to argue that the belief in the 'progressive' nature and 'curative' potential of the therapeutic community exemplifies the optimistic philosophy underpinning the whole environmental treatment movement.

Although there is evidence from the data to suggest that the concept of the therapeutic community is confused, it is nevertheless the case that continuity exists between the opinions of staff at all levels of responsibility. Whether in fact the few areas of disagreement reflect training influences or support for the policies of senior medical personnel on the grounds of respect for authority, does not disguise the fact that in general, medical, non-medical and nursing staff tend to uphold commonly understood principles relating to this approach to treatment.

General continuity of opinion does not, however, help to resolve the question of what constitutes a 'therapeutic community'. If such a question can ever be answered then it is likely that it will concern a series of specifically identifiable criteria of definition, rather than theoretically generalisable propositions. As was pointed out in chapter 6, a therapeutic community will use different methods for different groups of patients from another community and will be adjudged 'therapeutic' according to its ability ot achieve the goals expressed

by those in charge of the unit. As distinct from this, the 'therapeutic community concept' tends towards vagueness, but has an application, providing that its general propositions are not interpreted as being empirically identifiable features of individual communities.

It is clear from the answers to many of the questions in the interviews that a gradual amelioration of ideas concerning therapeutic community methods and aims, has taken place over the years. The influences of earlier studies and experiments, such as those of Maxwell Jones, the Rapoports, D.H. Clark and Stanton and Schwartz are noticeable in descriptions of treatment processes and general criteria of definition. Unfortunately, the lack of discrimination between the applications of these ideas has added to problems of interpretation with the result that the phrase 'the concept of the therapeutic community' has come to mean little more than 'the utilisation of the psychiatric milieu in the process of treatment'.

Although the present research findings cannot claim to alter this situation to any great extent, they do suggest certain underlying preferences which help to illustrate the kinds of structural factors and theoretical ideas common to the therapeutic community approach to treatment.

For example, the data suggests that (i) a preference exists for a relatively small (23 patients) unit, that is located outside or away from the larger organisation to which it belongs, having semi-autonomous administration and the right to determine its own therapeutic policy (Section5:2).

It further suggests that (ii) patients diagnosed as suffering from 'psycho-neurotic' and 'personality' disorders are considered most suitable for this mode of treatment (Section 3), although the (iii) 'therapeutic community' model or approach could be adapted to suit the needs of

patients suffering from a wider range of disorders (Section 8:2), (Section 10:1-3).

(iv) On the question of staffing policy, it is clearly thought that staff need to be selected for work in therapeutic communities and require a sympathetic personality as well as a considerable degree of tolerance, although a special training is not considered necessary (Section 8:4a, b).

(v) Therapeutic communities are clearly considered to require a democratic-permissive milieu, an emphasis upon communal responsibility and the use of confrontation techniques as a means of facilitating the interchange of opinions and ideas. (Section 5:1). These processes are viewed as essential aspects of the total approach to treatment. (Section7).

(vi) Despite a clear vote of confidence in favour of the therapeutic community as a satisfying work situation (Section 9:1) areas of role uncertainty exist which give rise to feelings of vulnerability, exposure and threat to authority (Section 9:2, 3, 4). Furthermore, apart from personal stresses, confusion over the definition of general aims and goals, as well as uncertainty over questions of discipline and authority are experienced by many staff (Section 5:3, 4).

(vii) There is no doubt that the 'therapeutic community' is viewed as a 'progressive' and challenging approach to the treatment of mental disorders (Section 3:1), (Section 4:2) and that it subsumes other methods of treatment under its general orientation, e.g. psychotherapy, psychopharmacology (Section 8:2).

Too often in the past the term 'therapeutic community' has been generalised to describe numerous types of psychiatric (and non-psychiatric) settings with the result that ideas concerning structure, treatment processes and goals have been either taken for granted as being similar or inadequately distinguished. The purpose of the interviews that have been described in chapters 7 and 8, was to try to establish some of the criteria that staff use to define the operation of therapeutic

communities.

Although many of the findings of this pilot study may appear familiar or even commonplace to those with experience or special knowledge of milieu therapy techniques, it is nevertheless the case that no real attempts have been made to establish whether the staff of therapeutic communities understand or agree with the principles of treatment and organisation laid down by innovating doctors.

On the basis of this brief analysis of the interview data it can be concluded that, on the whole, continuity of opinion does exist between all levels of staff concerning the general nature and purpose of therapeutic community methods of treatment, although, conceptually, areas of confusion exist which serve to obscure rather than clarify the differences in structural type and theoretical aims.

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STAGE 2

WOODSIDE VILLA: A STUDY OF A DEVELOPING THERAPEUTIC COMMUNITY

INTRODUCTION

Following the conclusion of the Pilot study in 1971, the researcher requested permission to engage in an intensive study of Woodside Villa, Shenley Hospital, which was previously visited during the course of the preliminary interviewing. The group Medical Advisory Committee granted permission for work to be carried out over a six-month period from September 1971 until March 1972, subject to the authority of the Ward Registrar.

At the time of application, the stated aim of research was to 'evaluate the process by which a hospital ward was undergoing development as a 'therapeutic community'.' It was suggested that specially designed techniques for data collection would be utilised providing that members of the community did not object to the presence of a researcher. It will be shown how different techniques evolved during the six months at Woodside, often spontaneously and with the cooperation of the patients as well as the staff.

Although a number of ideas for carrying out individual studies were discussed at the start of the project, there was no preselected research strategy, mainly because the field was still new to the researcher and required a period of involvement to gain the necessary experience of such a community, and because it would have been presumptious

to expect patients and staff to cooperate on a project about which they knew very little.

As the analysis of Stage 2 is considerably longer than that of Stage 1, it will be separated into appropriately headed chapters, as follows:-

CHAPTER 9	Shenley Hospital	The Problem of Ward Experiments
CHAPTER 10	Woodside Villa	Origins and Developmental Problems
CHAPTER 11	Woodside Villa	Devising a Research Strategy
CHAPTER 12	Woodside Villa	Preliminary Investigations
CHAPTER 13	Woodside Villa	Retrospective Analysis

CHAPTER 9

SHENLEY HOSPITAL

THE BACKGROUND TO RECENT WARD EXPERIMENTS

In order that one may fully understand the significance of the development of Woodside Villa as a psychotherapeutic community, it is necessary to understand something of the parent body, Shenley Hospital. Certain events warrant amplification so that the developmental difficulties of Woodside can be thrown into a meaningful perspective. Shenley Hospital was the last of a group of three hospitals built by the now defunct Middlesex County Council during the period 1841 - 1934. The first of these was Springfield, which opened at Tooting in 1841 with a compliment of 1,805 beds; the second was Napsbury at London Colney, and lastly Shenley, built in the Hertfordshire village of the same name, which opened in 1934 providing 2,000 beds and 15 padded rooms.

The major difference between Shenley and its two sister institutions was the innovation in architectural design whereby 24 detached villas were landscaped into a wooded hill overlooking a wide valley. Apart from the villa system three main ward blocks were built each containing six enclosed wards, surrounded by gardens and six-foot-high cast iron railings with locking gates.

When it opened in 1934, Shenley Hospital was unfortunately given the problem of dealing with many of the chronic patients of Napsbury and Springfield who were transferred in order to relieve overcrowding in those hospitals. During the period 1934 - 1939 total transfers amounted to 1,241, 384 male and 857 female. This trend was maintained

throughout the war years 1939 - 1945, during which time Shenley accepted all female admissions from Napsbury's catchment area in North Middlesex. "Thus within five years of opening, Shenley was provided by its sister hospitals with a ready-made chronic population...."[1] The report from which this quotation has been taken goes on to say that:-

"British institutional psychiatry during this period was operating at its lowest level of efficiency since the opening of the Retreat at York in 1792, and war-time restrictions contributed to this long-drawn out decline in standards. At Shenley, post-war developments and changes in staff attitudes did not start to produce visible results until 1957 when the peak patient population started to decline".[2] It is interesting to note that the total patient population was reduced in number from a peak of over 2,000 in the mid fifties to 1,037 by 31st December, 1969 which has been in keeping with the national trend.

The report quotes two major factors that are thought to have influenced the process of change during the 1940's and 1950's. Firstly, 'a change for the better' was brought about with the introduction of social psychiatric methods to hospitals though the engagement of psychoanalysts and hospital psychiatrists in the treatment of Armed Forces Personnel during the second World War. Secondly, the inception of the National Health Service "made money available for adequate staffing and made consultants responsible as equals for the standard of medical services".[3]

In 1947, the hospital was divided into three autonomous divisions, one male and two female. These divisions represent three North London catchment areas, Division A - Brent, Division B - Willesden and Acton,

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1 Annual Figures, Significant Facts 1969. Shenley Hosp. Central Medical Office P.2

2 Ibid P.2

3 Ibid P.2

and Division H - Harrow. Together they serve a population in the region of half-a-million people. By 1964, each division aimed to provide for its own area a comprehensive psychiatric service dealing with all types of disability other than mental subnormality including supplementary services such as clinical attachments to psychiatric wings of general hospitals, outpatient sessions and day centre involvement.

The nature of the changes that took place at Shenley during the period mentioned, are perhaps fairly orthodox in the light of general medical evolution. It is fortunate that a record has been kept of some of these innovations in the articles of one of the hospital's principle consultants who at the time of writing, was Chairman of the Group Medical Advisory Committee.

In an article entitled 'The Social Structure of the Mental Hospital', which deals very largely with Shenley, Bardon refers to the changing nature of patient-staff and inter-staff relations over the past 40 years, describing firstly what was professionally 'possible' or defensible in the Shenley 'Rule Book' of 1934.

He states that: "The rules tell us a lot about the formal social structure and the expectations of the founders and managers of the institution, the Middlesex County Council. This formal organisation did, of course, affect the behaviour of e.g. doctors and nurses towards each other and of both towards patients. It encouraged doctors to feel omnisicient, which they weren't. It encouraged the nurses to regard themselves as stupid, which they weren't. It confirmed an extremely rigid authoritarian, - hierarchical structure which stifled initiative, discouraged two way communication and thereby tended to create a rigid, anxious and largely custodial institution".[1]

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[1] Ibid Bardon D. P.3 (my italics)

If, as Bardon suggests, the 'therapeutic' climate of Shenley in the 1930's and 40's was of an hierarchical, custodial nature, has it modified to any great extent over the past three decades? He answers this question by describing the situation that existed in 1970.

"Well, a lot of old certainties have gone. Staff, particularly doctors, are much more self-questioning about their role, their contribution, their professionalism. In the process doctors have became much more aware of the essential professional contributions of other staff and more particularly of the role and contributions of the nurse... The doctors, having relinquished their traditional fantasies of omnipotence and omnisicience have now a much more realistic idea of their role and contribution. At the same time nurses, occupational therapists, psychiatric social workers and psychologists have changed and enlarged their concepts of their roles and contributions and feel free to say so... The railings and padded rooms have gone, the doors have been largely unlocked.... There is no rule book any longer..."[1]

Essentially, what has really changed at Shenley since 1934 is the structure of administration and the nature of medical policy making. The position of Medical Superintendant has been replaced by a 'group of equals', "an executive coalition of consultants who make medical policy decisions through the Group Medical Advisory Committee and have the power to implement these decisions".[2]

Bardon, argues that "hierarchical structure remains because it exists for the <u>essential purpose of identifying degrees of responsibility</u>".

He stresses however, that this form of responsibility "is no longer used as an invitation to the higher ranks and grades to kick the lower in

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1 Ibid P.4

2 Ibid P.6

a descending scale of tin pot Hitlerism, with the patients as the inevitable, final recipients of the accumulated frustration, sadism and despair". Instead, he adds, hierarchy and mutual respect are not incompatible, either in the context of between professionals or between professionals and patients.

It is possible, he argues, to have a hierarchical system of authority based on individuals understanding and respect for the need of a complex organisation "of defining, identifying and attaching responsibility where they belong. Before responsibilities can be attached, roles must be defined".[1]

Whether in fact it is possible to maintain such a system as this can be judged from an account of a situation that developed at Shenley during the mid 1960's.

It is suggested that during the period of the experiment about to be described, hierarchy and mutual respect were clearly incompatible, reflecting a basic inconsistency between what was stated in theory and what actually happened in practice.

The significance of the following discussion lies in the effect that the abandonment of the Villa 21 project had upon the morale of the hospital and in consequence, upon attempts to gather support for new ward experiments.

THE VILLA 21 EXPERIMENT : An example of poor communication.

On the 11th March, 1965 an article written by Dr. David Cooper entitled "Villa 21 - The Anti Hospital" appeared in the weekly magazine 'New Society'. In this article, Dr. Cooper described the development of an experiment in the community treatment of young 'schizophrenic' males that he was conducting in one of Shenley Hospital's Villas -

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1 Ibid P.4

referred to as 'Villa 21'. The patients with whom Dr. Cooper was working were very largely, severely regressed and dependent young men most of whom had been admitted to hospital on the grounds of requiring extensive 'psychiatric 'treatment' with no time limitations attached to their period of stay.

Dr. Cooper, a founder member along with Dr. Ronald Laing of the Philadelphia Association (London) and Director of the Institute of Phenomenological studies was known even in the early 1960's for his concern to develop 'existential psychiatry' in Britain and to "elaborate principles to overcome the methodological difficulties and compartmentalisation of the human sciences".[1]

The conflict that developed between Dr. Cooper and the hospital administration was to become an example of poor communication and misunderstanding between the two parties which has led to repercussions in other parts of the hospital in more recent years.

In his 'New Society' article, Dr. Cooper sought to explain the nature of the difficulties that he purported to be experiencing in Villa 21 in its relationship with the rest of the hospital. He wrote that:-

"A traditional psychiatric social context severely inhibits the internal evolution of such a community (Villa 21), even in a progressive, permissive hospital with considerable goodwill toward experimental developments. If staff attempt to meet psychotic patients on all levels of their existential voyage, and if they aspire, through increasing vision into their own inner worlds to become genuine guides to such patients, then they must be free of conventional institutional conformist pressures and their subtle violence". He then goes on to say that "The need for a fully autonomous unit in which these things may happen is clear and urgent".[2]

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1 Cooper D. (ed) Notes on Contributors: The Dialectics of Liberation. Pelican 1968, P.203.

2 Cooper D. Villa 21 - The Anti Hospital, New Society 11.3.65 P. (my italics).

Clearly, Cooper was stating that the difficulties he faced in administering the Villa were inextricably linked to the administrative policy of the hospital as a total organisation.

He refers to other factors inherent in the problem of managing a Villa along individualistic lines while still being subject to the administrative policy of the hospital. These can be summarised as follows:-

1. The mental hospital that functions traditionally cares for patients only as 'bodies', whilst their individual personalities are 'murdered'.

2. 'Authentic leadership' is the 'relinquishing of the impulse to dominate others'; 'domination' implies asserting ones personality over another (usually a weaker member); this form of 'domination' is an illusion of 'perfection' as in the case of the traditional doctor - patient relationship. The mental hospital along with Nazi extermination camps and other formal institutions is just another example of this 'dream of perfection'.

3. The notion of 'patient work' e.g. occupational therapy, domestic ward jobs etc., that exists in mental hospital practice, which is based on the assumption that work counteracts the process of institutionalisation manifested in symptoms of 'withdrawal' leading to chronicity - is a fantasy. 'Submission' of the patients to such requirements leads to the same end results.

4. If staff reject their role prescriptions as 'treatment providers' and 'activity organisers' and limit their involvement generally in ward and hospital administrative issues, even to the point of 'not doing anything' formally, they will be making a contribution equally, if not more valuable than that provided by the traditional nursing role.

5. A conventional hospital such as Shenley is totally alienated from the needs of the patients within it.

It is not difficult to see from what Cooper was saying in his article that his approach to patient care was radically opposed to the existing policy of the hospital.

Reaction to Cooper's Experiment

What followed the publication of Cooper's article was a statement of hospital policy written on behalf of the Hospital Management Committee, which implied that it was the doctor's personality rather than the philosophy behind the creation of Villa 21 that was to blame for the misunderstanding.

Bardon writes, in the article putting forward the hospital's point of view, that:-

"It can be agreed that Villa 21 has become the cause of a certain degree of anxiety and hostility - What Dr. Cooper calls 'conformist pressure and subtle violence'... We would submit that a considerable amount of the present hostility towards Villa 21 was NOT inevitable, need not have been aroused and is directly attributable to attitudes of Villa 21 staff, including Dr. Cooper himself, and for which he must accept responsibility".....[1]

The extent of this hostility can be guaged from the rest of Bardon's statement:-

... "These attitudes might be described as essentially a dismissal of the rest of the hospital as beneath contempt and beyond hope, combined with a morbid identification with, and an over-valuation of the psychotic and psychopathic patient. This paranoid arrogance has been introduced into an experimental situation as an artifact and is completely dis-

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[1] Bardon D. Reply to D. Cooper's article, Villa 21 - The Anti Hospital - New Society. Shenley Hospital unpubl. manuscript P.3 29.3.65 (my italics).

regarded by Dr. Cooper in coming to his conclusion, that the work which he has tried to do in Villa 21 is severely hampered because of the unavoidable hostility which it provokes".[1]

It seems obvious judging from the tone of this statement that the Hospital Management Committee saw Dr. Cooper as not only generating hostility towards the hospital, but also working in a manner that was unacceptable to the hospital body. 'Unacceptability', however, implies more than simply an objection to methods being used, it also implies the idea of one set of values being more legitimate than another. This point would seem to be borne out in the conclusion to Bardon's article. He states that:-

1. Hospital staff should not allow Dr. Cooper to invite them to 'invalidate his experiment' by becoming hostile to Villa 21. This would be "childish foolish and unscientific".

2. The hospital should not allow Dr. Cooper to alienate himself and Villa 21 by courting hostility; he should be encouraged to value the contributions of his co-workers rather than be permitted to undervalue them.

3. The hospital criticises Dr. Cooper's "disturbingly inaccurate premises on which many of his theoretical constructs are based". He only refers once to the work of other people, and, therefore, "This is a piece of unconventionality which we think should not be encouraged"....

4. The Hospital Management Committee is advised that there are precedents for the Villa 21 experiment elsewhere in existence in the form of two therapeutic communities which emphasise constructive attempts to treat 'tiresome and anti-social behaviour'.

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[1] Ibid P.3.

(This statement seems to imply that for Villa 21, to be seen to be constructive it should at least try to emulate well known, 'established' therapeutic community forms of organisation).

5. Untidiness, dirtiness, squalor and chaos are trivial in relation to some of the more important issues concerning Villa 21. However, the Hospital Management Committee is advised to continue to support the experiment.

6. "No unit in a hospital can be completely autonomous".

7. Finally, there would appear to be an element of inconsistency in the paragraph that states the hospital's appreciation of the work being carried out by Villa 21 staff "because of its immense stimulus value to the rest of the hospital".

Bardon seems to contradict himself (see paragraph 3) when he states that "The fact that there is disagreement about the theoretical basis for the mode of working is, at present, irrelevant".[1]

If it really was irrelevant then why does he talk of the 'disturbingly' inaccurate premises on which Cooper's theoretical constructs are based? Similarly, if Cooper's theoretical position was then 'irrelevant' why does he go to the trouble of saying that 'this is a piece of unconventionality which the hospital should not encourage?'

Though the articles representing the hospital's point of view were not published, it is important to realise that their circulation within the hospital was fairly widespread. It appears that the hospital staff were being informed by the Management Committee of the latter's attitude towards Cooper's unorthodox experiment. Since each member of staff comes under the authority of, and is accountable to the Management Committee, it is not difficult to see how 'hostility' to Villa 21 could have become

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[1] Ibid pp 7-8 (my italics).

a feature of the establishment rather than remaining simply a manifestation of a body of opinion. When Bardon was suggesting that staff should not accept "Dr. Cooper's invitation to invalidate his experiment by reacting with hostility to Villa 21", he was, perhaps unintentionally, doing just what he was asking his staff not to do.

The purpose of this brief analysis is not to judge which party was right or wrong, even more or less tolerant. Villa 21 serves as an example of how communications between a doctor and the administrative body of Shenley hospital became strained as each party sought to impose its will upon the other. One of the long-term effects of this communication problem has been that new ward experiments are subject to greater critical scrutiny from all levels of hospital management. When Conran took over Villa 21 from Cooper and began developing an equally unorthodox ward unit based upon psychoanalytical principles,[1] he encountered a great deal of suspiciousness and hostility from members of the medical and administrative hierarchy. Similarly, during the early stages of the development of Woodside Villa the registrar encountered, on a number of occasions, obstructions that he claimed were being created by the Governing body and the nursing administration.

It would appear then that Bardon's concept of hierarchy, defined as the necessary structure for the creation of responsibility, respect and sincerity is less sound in practice than in theory. For if it cannot accommodate with relative ease innovative methods and structures within the boundaries of its definition then it would seem that the concept itself is in need of revision.

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[1] Conran M.B. The Family as a Model in an Application of Psychoanalysis to the Care and Treatment of Young Male Schizophrenics. MD Thesis. Univ. London Jan. 1971.

It has been suggested by a member of Woodside's staff that the Villa failed to establish itself as an autonomous treatment unit owing to its dependence upon the hospital administration for such essentials as provision of staff, provision of food, furniture and household commodities, and more significantly, for ultimate sanctioning of ward medical policy. Clearly, a unit built as part of a large hospital cannot hope to be totally autonomous in its administration, however, if a compromise cannot be properly effected it suggests that the principle of delegating responsibility on the basis of respect is not adhered to, instead authority is wielded in an hierarchical manner. If a policy of hospital administration contains inconsistencies then it is not surprising that misunderstanding, poor communication and conflict are some of its end products.

The literature on the social organisation of the Mental Hospital is well endowed with examples of how problems of communication, conflict, and stress have been dealt with through the encouragement of joint decision making and collaboration.[1] It is significant to note from these studies that where conflict could be tolerated and accepted as an integral part of the process of change or innovation within a hospital the eventual result was usually beneficial to the organisation as a whole. This naturally raises questions as to the degree of importance that different hospitals ascribe to the same kind of problem, however, the point of comparing differential modes of reaction in this case is to emphasise the extent to which Shenley hospital has been relatively unable to tolerate, without significant intervention, the development of experimental treatment situations.

This aspect of administrative reaction should be noted, for it has a bearing upon the discussion of the development of Woodside Villa, to which we now turn.

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[1] A good example, Greenblatt M. et al, From Custodial to Therapeutic Patient Care in Mental Hospitals. Russell Sage Foundation NY 1955. pp.261-273

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CHAPTER 10

2 - WOODSIDE VILLA

ORIGINS AND DEVELOPMENTAL PROBLEMS

Woodside Villa lies on the northern boundary of Shenley Hospital overlooking a wide valley and as its name denotes, has perhaps one of the best geographical sitings within the hospital grounds, surrounded by trees and carefully maintained gardens. Despite the proximity of the hospital to London (fifteen miles from the centre) Shenley still gives the impression of being part of a rural community.

The villa system which allows for the separation of buildings by gardens at varying levels throughout the grounds, must be given credit for the unobtrusive appearance of the hospital - something which few of the hospitals in the London 'outer ring' can claim to possess.

It is perhaps somewhat ironic to learn that Woodside Villa was never intended as a residence for patients. In 1932, when the hospital plans were beginning to take tangible form, the building was designated as a maids' home and remained a staff-occupied residence right up until 1968 when internal reorganisation of hospital staff left it virtually unoccupied.

A series of events precipitated the Villa's transformation from a staff-occupied to a patient-occupied residence.

Two neighbouring villas, 8 and 9, female and male wards respectively, had, for some time, shared the same doctor and were both engaged in group psychotherapy. During the latter part of 1968, both villas were

informed of the hospital's intention to improve the sanitary standards of the two buildings by initiating extensive repairs. For a temporary period at least it was clear that the patients of both villas would have to be rehoused. It was at this time that a senior charge nurse of Villa 9 suggested the idea of integrating the two patient groups into one unit, given that their treatment situations were similar and that a sexually mixed population would be acceptable to the hospital administration.

The 'maid's home' was subsequently chosen as the unit most preferable and the idea was put forward for approval. On the 30th September, 1968 the patients and staff of both Villas moved into the old 'maid's home' and the building was renamed 'Woodside Villa'.

The patient population at the time of the move consisted of twelve female and ten male patients. The ward staff consisted of a locum registrar, two ward sisters and two charge nurses, a social worker and a psychologist. It is important to realise the significance of this particular staff combination. The ward doctor was an experienced Australian who had undergone a psychoanalytic training and was currently involved in the administration of analytically-oriented group psychotherapy. He maintained that his theoretical approach to group psychotherapy derived from the theory and practice of W. R. Bion,[1] the distinguished English psychiatrist.

Of the nursing staff, one of the charge nurses had worked with Dr. Cooper in Villa 21 and thus had first-hand experience of a new and unorthodox ward experiment. Both charge nurses and sisters had worked widely throughout the hospital, although their appointment to Woodside was accidental in the sense that the initial reason for moving them was

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[1] Bion, W.R. Experiences in Groups and other Papers. Social Science Paperbacks. Tavistock Pub. 1961.

not to create a special team, but simply to reallocate their services.

On a recommendation of the Registrar, the nursing administration did not allocate other grades of nursing staff to the new Villa. It was felt that in order to create a consistent staff-patient rapport, the staff would have to be as permanent as possible and it was thought that this would not have been feasible had nurses, undergoing training, been transferred to the Villa.

It should not be assumed that this recommendation was accepted with complete confidence by the hospital administration. General nursing policy advocates the placement of staff in training in wards for maximum periods of thirteen weeks only.[1] The average period of stay in any ward is between six and eight weeks. Thus when the Registrar recommended that junior nursing staff should only be employed at Woodside for minimum periods of six months he was creating a precedent of a kind that must have been difficult for the administrative body to veto. Given that the Group Medical Advisory Committee, was basically in favour of supporting new ideas in Ward Management it would have seemed unsympathetic to the Registrar if the Committee had over-emphasised the need to maintain orthodox nursing practices.

The unusual involvement of the social worker and the psychologist at Woodside Villa was determined very largely by the need for a coherent psychotherapeutic group policy.

The social worker who was attached to the new Villa had been in group therapy training and was interested in becoming involved in group work at Woodside. Three groups were established with roughly seven patients in each. The three group 'therapists' or 'leaders' were

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[1] This policy is undergoing alteration following the recommendations of the Salmon Report.

respectively the Registrar, the psychologist and one of the charge nurses. The social worker joined the psychologist's group. Only the registrar out of the three 'therapists' had both formal psychiatric and group therapy training.

The psychologist ran his group for nearly a year before leaving the hospital, in order, amongst other things, to train in the practice of group psychotherapy. The group that he left was taken over by the social worker who had, by then, been co-therapist for seven months.

In any conventional hospital situation it would not be usual to find either social workers or psychologists involved in psychotherapeutic group-work.

From the start, therefore, Woodside was considered to be unconventional in that it encouraged inter-disciplinary involvement of staff in Villa life, and significantly, through this involvement, it stressed an inward-looking approach to patient care rather than a conventional 'external' role playing which is largely characteristic of traditional social work and of clinical psychology.

The involvement of social workers at Woodside Villa during its early stages was clearly based upon a recognition by interprofessional groups that their contribution to the ward programme lay as much in the psychotherapeutic process as in the fulfilment of their external social work roles.

The researcher was made aware during the course of informal conversations with members of Woodside's staff, however, that the Chairman of the Group Medical Advisory Committee was clearly not in favour of social workers' involvement in psychotherapy regardless of psychotherapeutic training. There was resistence on the part of the

administrative body to social workers joining or assuming leadership roles in patient groups. Ironically, in a paper dealing with psychiatric aspects of medicine and the Social Services, the Chairman accepted the recommendations of the Seebohm Report on the need for interprofessional teamwork.

"Any adequate attempt by doctors to assist in meeting reasonable medical-social demands or known medical-social needs will necessitate a willingness on our part to work with colleagues from other disciplines who claim for themselves professional status.... Authentic and effective interprofessional relationships can only be based on a realistic appraisal of each others potential contributions. Doctors must give up the assumption that we have a right to the leadership of professional teams. The myth of the leader is the oldest, most persistent and most deadly myth that has ever bedevilled humanity. If we and society cannot accept and apply the concept of corporate or group responsibility we shall contrive our destruction in double quick time...".[1]

Bardon stresses the need for social workers to be recognised as fellow-professionals in the psychiatric field, but indicates that co-operation must take the form of complimentary, rather than overlapping modes of involvement.

This would imply that the boundaries of the two professions are delineated in terms of role expectations. Earlier in his article, he defines the word 'profession' as: "an organised body of people, accepting an ethical code of professional conduct, who, by reason of a rigorous training have acquired special knowledge and skills which enable them to make a unique contribution to an attempted solution of a particular class of problems, in which attempt they may be associated with other professions".[2]

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1 Bardon D. Psychiatric Aspects of Medicine and the Social Services. Unpub. Paper. Shenley Hospital. 1969. pp.2-3 (my italics)

2 Ibid P.2.

The problem that arises for the social worker, or for that matter any other newly defined 'professional', is that roles are not as clearly defined as they are for the psychiatric doctor. At a time when changes, such as those recommended in the Seebohm Report, are in operation, it is difficult for, say, the social worker, not to think of her new role as encompassing wider horizons. If a social worker is connected to a ward team, for example, all of whom are expected to participate in ward meetings and take part in the innovation of new ideas, it is to be expected that her conception of her role will change and widen accordingly.

Although involvement as a therapist in psychotherapy does require training, who is to say that the social worker undergoing a course or having finished a training in group psychotherapy should not then hope to work as a psychotherapist simply because no such provision exists within the professional definition of the social worker's role?

If, as Bardon suggests, doctors must give up the assumption that they have a right to the leadership of professional teams, and if, as he also suggests, authentic and effective interprofessional relationships can only be based on a realistic appraisal of each others potential contributions, is it not fallacious to argue that one group of professionals should be excluded from a field in which they might become further involved because their 'special knowledge and skills' do not fit this 'particular class of problems?'.

It is suggested that Bardon's interpretation of 'professionalism' may have been a contributory factor in the resistence to social workers becoming involved in psychotherapy at Woodside Villa.

An example of this resistance occurred in the case of a psychiatric social worker who was asked to take over a departing therapist's group.

It was mentioned earlier that Shenley hospital's catchment areas were divided up into three divisions: A, B, and H. Within the hospital each division had its own social work staff allocation and it was generally agreed that these divisional staff would not encroach upon each others territories. When in 1970, however, the position of group therapist fell vacant at Woodside Villa someone with the necessary potential for group work was required at short notice. Woodside's registrar recommended that a male psychiatric social worker from 'H' division should fill the vacant post. The position was duly filled and the group was enabled to continue, albeit on different lines.

Reaction to this unorthodox appointment was experienced less in the form of direct intervention than in the form of criticism which appeared to filter down through the various ranks of staff, finally to appear at nursing level in petty remarks about 'pinching staff'; having special privelages and so forth. Negotiations that took place at various times between the ward doctor and the Group Chairman seem to have led to what has been described as a 'longstanding difference of opinion' between the two doctors. Whatever the nature of this division, it was experienced both by patients and staff in different forms, ranging from agitation about not getting ward requests passed by the administration, to direct intervention by senior nursing and medical staff in ward affairs. The intangibility of the problem and the absence of proof of disagreement or hostility, in no way diminishes the reality of the situation. It is perhaps a measure of the anxiety that must have been experienced by the Group Chairman and the ward doctor that the differences of opinion with regard to ward matters were not adequately resolved nor made publicly known to Woodside's staff. It will be shown in due course how this underlying conflict played a significant part in the generation of

anxiety and disturbed behaviour amongst the patients in the Villa.

The creation of Woodside as a sexually mixed community did not take place altogether free of anxiety and administrative intervention. In an unpublished paper entitled 'Woodside - an improbable possibility' Atkin, Charge Nurse and one of the original therapists, wrote that:-

"The move was preceded by considerable anxiety in the patient population and among the senior echelons of the staff hierarchy. The former expressing itself by way of an atmosphere of tense expectancy, some minor acting out here and there and one or two precipitate, autonomous discharges. Staff anxiety was manifested chiefly at senior medical and nursing administration level and found expression in some confused and confusing meetings during which almost nothing at all transpired that had any value for the people who were going to be in the middle of the project".

However, he goes on to qualify this statement by pointing out that:-

"The enthusiasm, confidence, and competence of the floor-level nursing staff was.... a source of considerable reassurance to those who felt themselves to be the responsible people..."[1]

It is further interesting to note that Atkin saw the common factor in this anxiety as <u>discontent</u> on the part of both patients and staff. "Everybody concerned was, for one reason or another discontented with the boredom and sterility of the usual ward situation in the standard mental hospital and the two-dimensional nature of the functions they were variously expected to fulfill... this was a group of patients and staff moving into a situation which had no precedent in the hospital whatsoever.... everyone concerned was totally new to it, and... there was no fund of experience anywhere in the hospital which fitted every aspect of the situation and

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[1] Atkin F. Woodside - an improbable possibility. Unpublished Paper. Shenley Hospital January, 1971.

could be drawn on for guidance or advice. A sexually mixed group of patients and staff moving into a ward without dormitories for the purpose of pursuing something called Group Psychotherapy in a community setting was a first time event in this hospital".[1]

Anxiety of the kind referred to above is not confined simply to those people directly involved in such ward changes. Patients, staff and administrative officers were reacting in the case of Woodside to a set of situations that involved each person in an assessment of his or her responsibility to the ward and its residents. Atkin comments poignantly on the hospital staff's reaction to Woodside Villa:

"Total approbation, measured approval, sly cynicism, intellectual dissatisfaction, high moral indignation, disapproval, curiosity, puzzlement and plain apathetic indifference. All these attitudes have been encountered in the hospital at large. The place (Woodside Villa) has been variously described as a home-from-home, a layabout's paradise; a bright spot in an arid landscape; a brothel and/or a holiday camp... On examination one finds that these descriptions apply more readily to the fantasies of the describer than to Woodside itself".

"Since the fantasist disapproves of fantasies", he goes on, "it emerges that Woodside fulfills a function for the larger hospital in being simultaneously the object of illicit and perhaps wistful fantasy and the target for righteous disapproval of such decadence".[2]

Atkin's article contains a great deal of insightful information on the developmental difficulties of Woodside Villa. He does not hide his basic dissatisfaction with traditional psychiatric theory and practice, and he makes use of this position to explain how, in his opinion, many

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1 Ibid P.3 (my italics)

2 Ibid P.7 (my italics)

people within the hospital holding similar views, looked for the first time to Woodside Villa for new hope in the treatment of acute disorders. Despite the negative reactions to the new project that are mentioned above, Atkin saw this expression of "fearful hope" as the one positive result of the attempt to create a new kind of unit based on a different treatment philosophy.[1]

It may even be that the notion of 'uniqueness' that was always ascribed to Woodside was as much a by-product of an ambivalent interest in the developments as it was a genuine interest in new modes of living and treatment situations.

It is often the case that something which comes to be regarded as 'special' is merely the recognition that certain ideas or methods of working are 'new' or 'different'. Atkin feels that the interest, whatever its nature, which was taken in the new unit by external hospital staff, gave rise to a feeling of 'specialness' within Woodside Villa. He lists five characteristics of 'specialness' that can be attributed to Woodside:-

1. The attribution of a unique character to the Woodside community by people outside it which is internalised by its members.
2. Accommodation of the patient population in individual rooms instead of dormitories.
3. Sexual integration of patients under the same roof, as in the sense of a 'family'. This implies more than simply patients being accommodated in male and female groups in the same building, it stresses instead the importance of patients <u>living together as a community</u>.
4. Unorthodox staffing arrangements in that there are three male and three female nurses operating three sexually mixed shifts in pairs, each

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[1] Ibid P.7

member of which is the peer of the other.

5. The ward functioned around and was oriented towards group psychotherapeutic treatment.[1]

If one looks at these characteristics as the principle components of a new ward culture it is possible to see how the production of anxiety was largely a consequence of the creation of something 'different' or 'special'. As Atkin has pointed out, Shenley Hospital had never experimented with a mixed unit before and the creation of such a unit resulted in the diverse reactions that have been mentioned above. Woodside was not just different, it was altogether an unknown quantity.

The structure of staff authority at Woodside resembles neither the conventional ward seniority pattern that was in existence throughout the rest of the hospital, nor the pyramidial type of staff structure laid out in the Salmon Report of 1966. Two nursing sisters and two charge nurses working mixed shifts during the day and evening was an unorthodox practice which gave rise to considerable criticism from other hospital staff, partly through feelings of indignation about a precedent being allowed in such a case. It may have been that other staff who were subject to more rigidly defined authority structures were envious of the apparent freedom of communication and flexibility of working relationships that existed between the staff at Woodside.

The accommodation of patients in individual rooms rather than in dormitories was made possible primarily because the maid's home had been designed to accommodate individual staff members. This special feature of residence was unique in that it could not be copies anywhere else in the hospital because the availability of the maid's home as a patient residential villa, itself arose out of a unique set of circumstances.

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[1] Ibid P.8

With the added advantage that the Villa could still be divided into male and female sleeping accommodation without losing the feeling of communal residence, Woodside once again was clearly different from other wards in the hospital.

It is not difficult to understand how the imaginations of hospital staff could have run so wild as to liken Woodside to a 'brothel' or a 'layabout's paradise'. The Villa itself was geographically isolated from other wards. The treatment orientation was different enough to be regarded as 'suspect', and the communal-living-situation, which provided the kind of freedom of interaction in which group psychotherapy could function, must have appeared to hospital personnel extraordinarily 'lax' when compared to that of other wards.

The policy of giving patients individual rooms was quickly likened to hotel accommodation, and the notion that patients were 'layabouts' probably arose out of the feeling that Woodside's patients were specially privelaged.

The issue of sexual integration of patients and of staff is of special significance. Hospitals, whether psychiatric or general, have traditionally segregated male and female patients. Despite the growing number of examples of sexual integration in modern hospitals, it is still common policy to find segregation of the sexes in practice. In the case of Shenley hospital, as in most older hospitals today, the structure of divisions, ward blocks and wards themselves reflect the practice of sexual segregation. Shenley's 'male' and 'female' blocks, comprising six combined male and six combined female wards respectively, are just such examples of the old order. Massive reorganisation would be required to integrate male and female patients throughout the hospital and at present

such an idea is not realistically entertained. Structural innovation within and between wards, however, is a different matter altogether. In the case of ward changes, the difficulties in innovating tend to be due to a lack of enthusiasm rather than to structural impediments.

It is, therefore, not surprising to find, in the case of Woodside Villa, that sexual integration of patients was easily misunderstood and misrepresented by hospital staff. Integration of the sexes within one building was rapidly misconceived as meaning 'sexual licence', or the condoning of 'illicit sexual practices'.

The last major characteristic of the special ward culture of Woodside Villa which shall be discussed is the practice of Group Psychotherapy - perhaps the most important since it is around its process that the other characteristics take on meaning. The purpose of this chapter is not to discuss the dynamics of the process and its claims, but simply to determine how far its development at Woodside played a part in the creation of anxiety within the ward and the wider hospital body.

Psychotherapy, particularly of a psychoanalytic nature, seeks to establish a dialogue between therapist and patient. Depending upon the particular kind of stance adopted by the therapist or analyst towards his client, psychotherapeutic relationship will vary according to how far emotional and physical interactions play a more or less important part in the establishment of dialogue. Group psychotherapy as distinct from individual psychotherapy seeks to widen the scope of these interactions to encompass the group as a totality of individuals whose common bond is the privacy and security of a unique group subculture.

The three groups that were originally intitiated at Woodside Villa did not all share a common analytic approach. Atkin's group could not

be said to have identified with any distinct approach although it may have borne a closer resemblance to existential rather than psycho-analytical psychotherapy. Only the registrar's group laid claim to a particular form of group analysis.[1]

Staff members with no formal group experience were asked to participate in the groups and most became involved. Atkin notes that "staff generally, and nursing staff in particular, participating in the therapeutic situation will experience modification of attitudes and ideas along with everyone else. If the pre-conceptions, responses and role choices of patients are called into question by the group and its members, the preconceptions, responses and role choices of nurses, doctors and therapists are also open to question".[2]

The resultant effects of involvement in group psychotherapy for Woodside Staff may have been as important in the genesis of a special ward culture as was the involvement of the patients. Staff anxiety was manifested initially in feelings of hesitation about 'working outside one's role' and of making oneself vulnerable by being open to criticism from patients. Atkin states that the activities of any live psycho-therapeutic group are essentially 'subversive' in that the group process denies the possible maintenance of the status quo. in staff-patient relationships.

"A significant outcome of this is that hospital staff in the situation find themselves surrendering many of the protective/defensive characteristics of traditional staff roles. This is a disturbing situation and... the resulting accessibility and vulnerability makes it often exhausting and sometimes dangerous".[3]

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1 See note 1, P. 259

2 Ibid P.14

3 Ibid P.14

The existing literature on the role of the nurse in psychiatry is too large to make possible here a competent appraisal of other accounts of anxiety and vulnerability experienced by nursing staff. One useful comparative example may perhaps suffice under the circumstances. In their book "Psychiatric Ideologies and Institutions", Schatzman, Strauss et al examined the nature and consequences of nurses involvement in psychotherapy. The sought to establish which specific therapeutic roles a good psychiatric nurse should be encouraged to play; how the nurse acts as an auxiliary agent in therapy; and how the nurse can determine the degree to which he or she is helping a patient to improve.

They concluded that two of the main by-products of this involvement are the creation of anxiety and the awareness of being vulnerable to criticism. Furthermore, they stress that those nurses who were studied were accountable both for ward management and for therapeutic behaviour and that this second form of responsibility constituted the major source of anxiety. They would receive criticism from the administration and from colleagues "for actions that should have been therapeutic but were not", and they were "reproached by attending physicians for becoming "overinvolved" with patients and thus producing untoward effects on them". The nurses were exposed to many forms of attack. "A nurse may be criticised by her colleagues, by the aides, by the head nurse, by the nursing administration, by various psychiatric administrators and by each attending physician with whose patients she comes into contact... In addition every nurse is open to criticism by patients who may shrewdly find chinks in her protective armour or genuine deficiencies in her therapeutic performance".

In examining the possible reasons for this criticism, attack and resultant anxiety, the authors suggest that nurses are more vulnerable

than other staff because they assimilate psychotherapeutic concepts thus becoming what may be termed "minimal psychiatrists" whilst not having the professional protection that the psychiatrist's role affords.

"Psychiatrists appear to be considerably less vulnerable to this kind of therapeutic criticism.... because they are institutionally protected against it. In the hospital they stand in superordinate relationships to most personnel, which affords some protection..... Perhaps nurses are also more vulnerable than psychiatrists because they operate with a minimum of psychiatric knowledge. Having far less systematic and extensive psychiatric education they have less conceptual equipment with which to defend themselves against criticism. They are more open to accusation about their motives because they are less practiced in thinking about themselves in theoretical terminology and at a psychological distance".[1]

Much of what the authors are here referring to would support Atkin's observations of nursing role modifications at Woodside Villa.

The ability to contain personal anxiety is largely a function of the degree to which an individual is able to modify his perception of any given role in relation to changing situational demands. Thus the nurse who is able to cope adequately with criticism from patients and other staff is likely to be less rigid in defining the role of the nurse in psychotherapeutic ward situation. If the ward team's esprit de corps is strong and treatment goals are generally understood it should be possible for the anxious staff member to receive support from other staff in coming to terms with the anxieties arising from role modification.

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[1] Strauss A. et al Psychiatric Ideologies and Institutions. Free Press, Collier-MacMillan London 1964, pp.213-6.

Where common goals are misunderstood or are not shared, confusion and destructive role playing can easily result.

At Woodside Villa, staff and patient understanding of the psychotherapeutic treatment policy seems to have been consistent. The early stages of innovation appear to have been characterised by growth rather than stagnation which would imply that modification of traditional roles and internalisation of new role prescriptions took place relatively unimpeded. "It is to the credit of the staff in the situation" writes Atkin, "that this possibility was not obliterated by regression to traditional institutional customs and values, despite the comfort and reassurance to be found therein".[1]

The emphasis laid upon the need to create an atmosphere in which patients and staff could feel as if they were 'living together' can be seen in the manner in which each individual took on a responsibility towards the rest of the villa residents. Participation in psychotherapeutic groups emphasised the importance of taking others into one's confidence and of building up relationships based upon among other things, an intimate understanding of how each individual reacted to living in close, often claustrophobic, communal surroundings. The experience of the groups were inextricably bound up with the wider experiences of the Villa's living situation. Toleration of disturbed behaviour was expected without recourse to formal intervention, and for this reason, the culture of Woodside had to be strongly supportive to prevent the development of extreme anxiety amongst the patient population.

The practical running of the ward was shared between patients and staff with the patients accepting greater responsibilities as time went

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1 Atkin F. Op Cit P.15.

by. No patients, regardless of diagnosis, were considered 'disabled' and, therefore, each person was considered to be a responsible member of the community. How the notion of 'therapeutic community' was interpreted and developed by the staff and patients of Woodside Villa will be explained in the following account of the author's involvement there during the period September 1971 to March, 1972.

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CHAPTER 11

WOODSIDE VILLA

(ii) DEVISING A RESEARCH STRATEGY

At the time of the researcher's initial involvement at Woodside Villa, considerable uncertainty was being expressed about the nature and purpose of the Community. Although on occasion, the term 'Psycho-therapeutic community' was used to describe the general approach to treatment, it meant little more than the 'practice of group psychotherapy in a hospital ward community'. There is little doubt that the use of the 'milieu' as a supportive agent in treatment was understood in principle, however, no attempt had been made to formulate a therapeutic policy taking into account all of the factors constituting a 'milieu therapy' approach to treatment.

It was largely due to the absence of definitional criteria and a clearly stated policy on the function of the 'milieu' in treatment, that Woodside was chosen as the subject for further study.

During the course of the researcher's interviewing at Shenley, earlier in the year, the medical Registrar at Woodside suggested that a sociologist could be 'usefully employed' in helping to clarify some of the more important issues involved in utilising aspects of the ward's social structure and culture in the furtherance of treatment.

The uncertain nature of the work required that the research strategy be both flexible and informal. This meant that from the start, the role

of the researcher would be action-oriented. As a participant observer, it was envisaged that he would become involved in all aspects of ward life, instead of merely playing the role of a passive recipient of information.

It was mainly for these reasons that the choice of theoretical orientation favoured 'grounded' as distinct from 'logico-deductive' theory and preference was shown for informal techniques of data accumulation.

(i) Grounded Theory[1]

Glaser and Strauss claim that 'grounded theory' is a "way of arriving at theory suited to its supposed uses". In other words, unlike theory generated by logical deduction from a priori assumptions, 'grounded theory' is 'discovered' from data systematically obtained from social research. They hold that theory is a strategy for handling data in research in which modes of conceptualisation for describing and explaining are provided. The validity of a theory, it is argued, depends upon the satisfaction of certain criteria; namely that (a) it should provide clear enough categories and hypotheses so that crucial ones can be verified in present and future research, (b) it must be clear enough to be readily operationalised in quantitive studies when these are appropriate, and (c) it must be readily understandable to sociologists of any viewpoint. Theory that meets these requirements is said to 'fit' the research situation without there being any need to 'force' the correct conclusions from the data.[2]

It was mentioned in a previous chapter that the adequacy of a theory for sociology cannot be divorced from the process by which it is generated.

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1 Glaser B, Strauss A. The Discovery of Grounded Theory: Strategies for qualitative research. Weidenfeld & Nicholson 1967.

2 Ibid PP. 2 - 3.

This principle is central to the advancement of 'grounded theory' as distinct from logico-deductive theory because it stresses that theory based on data cannot easily be refuted by more data or another theory. Unlike logically deduced theories such as those on the 'social system', which tends to require that the data fit the theory rather than theory and data being reciprocally interrelated during the process of research, grounded theory is inductively generated from social research.

Due to the emphasis placed upon the need to be 'scientific' in sociological research, qualitative methods have in the past tended to be relegated to preliminary, exploratory work in which only basic hypotheses are generated which are later tested by more rigorous quantitative procedures. As a result greater interest has been shown in the use of 'verification' procedures than in methods of generating theory from data.

'Grounded theory' on the other hand is mainly concerned with the collection and elucidation of qualitative data by means of comparative analysis. Through constant comparison with similar groups of phenomena, facts arising from the data of research can be checked and validated. The logic behind any formulation of this method concerns the need for replication, since the ability to reproduce a 'fact' is the means by which it is validated.*

Comparative analysis does not, however, exclude the use of statistical or other methods of verification, it simply provides a means by which groups of data can be meaningfully compared during the course of the development of theory. Theory seen as a 'process', or an "ever-developing entity" as distinct from a "perfected product", allows for the use of comparative techniques which lead to the generation of 'working hypotheses'.[1]

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* It is recognised that K. R. Popper's critique of inductive logic opposes this approach to 'scientific' fact finding.

1 Ibid pp.32-3

Glaser and Strauss claim that the creation and rejection of 'substantive' theoretical conceptualisations leads ultimately to the establishment of grounded 'formal' theory; that is, when an area of knowledge has been sufficiently well examined and has resulted in the advancement of general conceptual categories (e.g. stigma, deviant behaviour,) which represent the central principles of the theory. Unlike the procedures usually connected with formal empirical studies whereby hypotheses are derived from previous studies or theories, or from pilot research, 'grounded theory' allows for the generation and verification of new hypothese during the course of research. The authors comment that:

"Whether the sociologist as he jointly collects and analyses qualitative data, starts out in a confused state of noting almost everything he sees because it all seems significant, or whether he starts out with a more defined purpose, his work quickly leads to the generation of hypotheses. When he begins to hypothesise.... the researcher is no longer a passive receiver of impressions, but is drawn naturally into actively generating and verifying his hypotheses through comparison of groups. Characteristically, in this kind of joint data collection and analysis, multiple hypothese are pursued simultaneously. Some are pursued over long periods of time because their generation and verification are linked with developing social events".[1]

The type of procedure just described, typified the approach adopted at Woodside Villa. The absence of previous research data required an exploratory frame of reference for research and for this reason it was decided that a varied combination of theoretical and methodological ideas would suit the research situation at Woodside.

Through (i) participant observation, it was assumed that basic data

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[1] Ibid pp.39

could be accumulated which would help to illustrate aspects of the culture of the community, (ii) Diary notes were to be kept, relating all events taking place within the villa and these were to be complemented by information about the patient population extracted from ward reports by means of (iii) content analysis. During these early stages it was hoped that a series of basic assumptions and hypotheses would be generated from which further strategies for collecting data would derive.

The interview data from the first stage of the research project provided the researcher with some of the basic information concerning therapeutic community treatment methods. It will be remembered from chapters 7 and 8 that hospital staff tended to describe the 'therapeutic community' in organisational or structural terms.

For example, taking an aggregate of all interview responses, the 'ideal type' therapeutic community appears as a small, semi-autonomous ward or unit, located away from the administrative body to which it is responsible, treating up to 23 patients expressing symptoms of 'psychoneurotic' or personality disorders. A democratic-permissive 'milieu' is favoured in the majority of cases as is the practice of communal responsibility in decision making and the use of 'confrontation' procedures.

In some respects, Woodside Villa resembled this basic conceptualisation of a therapeutic community. In September 1971, this externally-located villa housed 20 patients and eight staff, (excluding visiting therapists). Although it was generally agreed that patient selection was not based upon diagnostic evaluation, most patients were under 30 years of age and were thought to be expressing a wide range of 'personality disorders' of the 'hysterical' or 'obsessional' type, compared with a smaller number of

patients manifesting symptoms of 'psychotic' disorder.

It could be argued that Woodside was semi-autonomous in terms of administration, although its need to depend upon the wider hospital body for most facilities limited the extent to which autonomy could be expressed.

The medical registrar explained at the start of the research project that he was concerned to understand and to utilise the social environment of the Villa in the wider process of treatment and for this reason interest had already developed in the use of democratically-oriented decision-making machinery. In the larger group meetings, open discussion and confrontation was encouraged with an emphasis upon the 'group's' resolution of conflicts and day to day problems. Treatment, although it encouraged the total experience of the patient over the full twenty-four hours of every day, was more explicitly taken to mean the experience deriving from participation in group psychotherapy. This particular interpretation derived from the Registrar's belief in the 'special' value of participation in a psychoanalytic setting.[1]

From the beginning, Woodside Villa projected a distinctive character from which numerous possible ideas for study emerged. Here was an external ward of a large mental hospital attempting to develop a special culture; aware that the term 'therapeutic community' could be applied to the overall approach to treatment, and yet hesitant about using any descriptive 'terms' that might give the impression (i) of something radically different taking place within the hospital administrative structure, or (ii) that the use of a 'label' might simply be a convenient way of climbing on a popular bandwagon. This sense of reservation was due to an awareness that 'doing something different' arouses suspicion and

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[1] See Chapter 12 for further discussion of these issues.

gives rise to anxiety within administrative circles as was evident for example, in the case of Shenley's Villa 21 project. Furthermore, adopting the term 'therapeutic community' without careful consideration of its meaning and application can also result in misinterpretations of the aims of treatment.

On first sight, the dynamics of the research situation were fairly complex. What was therefore required was a set of simple propositions that would help the researcher to interpret the events taking place in the Villa in some kind of orderly manner. Some of the initial assumptions upon which research was grounded were as follows:-

1. Woodside Villa was a psycho-therapeutic community seeking to understand more about the influences of social interaction and the social structure of the unit, upon patients and staff.
2. The term 'therapeutic community' although only occasionally used, was generally understood to apply to the Villa's attempt to use the social 'milieu' more effectively in treatment process.
3. A sense of 'being different', 'being more progressive', accompanied the growing understanding of the uses of the 'milieu' in therapy.
4. The medical Registrar believed that the application of sociological ideas to these questions could help to develop a more structured approach to psychotherapeutic treatment in a hospital community setting.

(ii) Participant Observation

It was mentioned earlier that it would have been inappropriate for the researcher to have been a marginally involved, passive recipient of information. As a participant observer it was obvious from the start that he had to become actively involved in all aspects of ward life if

patients and staff were to understand and trust his methods of working. Furthermore, if continuity was to be ensured there would have been little point in participating in some situations and not others.

Participant observation studies take a number of different forms. It would be inappropriate at this point to discuss all of their varying applications,[1] therefore, one or two examples may suffice to explain the essential aspects of these approaches.

Schwartz and Schwartz have defined participant observation as a "process in which the observer's presence in the social situation is maintained for the purpose of scientific investigation".[2] It differs from other methods such as the interview in that the subject observed is not usually aware that the investigator is using his behaviour as a source of information, and therefore, allows for a considerable degree of affective participation in the study situation before bias or distortion take place.

Two modes of participant observation are identified by the above-mentioned writers:-

(a) as a role activity in the research situation and,

(b) as an affective participation in which the investigator's emotional responses are evoked in the situation.

The difference between these two approaches is one of degree, since the interplay between observer and observed can be related to variables on a passive-active continuum. At one end, 'sympathetic identification' is thought to be free of distortion, whereas at the other end, 'projective

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1 For a series of useful accounts of these methods see 'Issues in Participant Observation', A Text and Reader'. Eds. G. J. McCall, J.L. Simmons. Addison-Wesley Pub. Co. 1969.

2 Schwartz M.S. & Schwartz C.G. Problems in Participant Observation. American Journal of Sociology, 60, Jan. 1955 pp.343-353.

distortion' is thought to encourage bias deriving from the 'personality constellation' of the observer. Schwartz & Schwartz claim that in the latter case it is better to admit to one's biases than to allow them to become hidden, intrusive variables.

In practice, participant observation is described as a succession of steps in which the length of time between the event and its recording increases from one step to the next. For example, recording in memory takes place (i) in the split second subsequent to the event during which it is registered, whereas shortly afterwards (ii) interpretation of its significance in the context in which it occurred takes place, and finally (iii) transcriptions of the event into data takes place.

Therefore, participant observation is a "process of registering, interpreting and recording".[1]

Depending upon the extent to which the investigator feels that he is an integral part of the situation that he is observing, his 'active' participation will vary in degree of commitment. The 'active' as compared with the marginally involved observer "attempts to share the life of the observed on a simply human level as well as on a planned role level and uses both these modes of participation for research purposes". In the hospital setting, this kind of role playing enables the observer to become involved "in planned interventions in the social structure with the ward staff for the purpose of developing a more therapeutic milieu".[2]

As one can see, this description of role playing compares favourable with the situation experienced by the researcher at Woodside Villa, since it was an expected part of his involvement that he would not only observe the ongoing therapeutic milieu but would also advise upon its development

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1 Ibid P.344

2 Ibid P.349

and effectiveness.

Becker makes a further, useful point when he argues that sociologists who use participant observation methods "are especially interested in understanding a particular organisation or substantive problem rather than demonstrating relations between abstractly defined variables. They attempt to make their research theoretically meaningful but 'they assume that they do not know enough about the organisation a priori to identify relevant problems and hypotheses and that they must discover these in the course of research".[1]

The grounding of data in research by means of participant observation is, therefore, an important sociological enterprise. The real problem encountered in observational research, claims Becker, is not the manner in which it is collected but the means by which it is systematically analysed and presented in a form that will convince others of its validity. Therefore, the way to overcome this difficulty, he continues, is to carry out parts of the analysis during the course of data collection.

In the psychiatric hospital setting, participant observation can involve taking the role of a patient as well as an additional member of staff. This technique of data collection is generally associated with the work of Caudhill[2] and Goffman,[3] however, a recent example of a study of a milieu therapy setting by this technique bears perhaps more relevance to the present study.

In a study that took place at the Fort Logan Mental Health Centre, Colorado in 1963, Kjolseth lived on one ward as a '24 hour' patient for eight consecutive days. His purpose was to describe his observations

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1 Becker H.S. Problems of Inference and Proof in Participant Observation. American Sociological Review, 23, 6, Dec. 1958 P.653 (my italics).

2 Caudhill W.A. The Psychiatric Hospital as a Small Society. Cambridge Mass. Harvard V.P. 1958.

3 Goffman E. Assylums. Chicago Aldine Pub. Co. 1961.

of patient culture on this ward.[1] The description that he provides of his initial involvement exemplifies the kinds of uncertainty experienced by investigators in this kind of study of psychiatric settings. He states that "I had been visiting Fort Logan during the previous year on a one-day-a-week-basis and had participated in several of the treatment programme activities. My participation as an outsider in the formal schedules activities had given me little inside information on the informal activities. I had rehashed experiences with staff, but not with patients. I had seen isolated events but not in their situational framework or natural flow. Having come to feel that my understanding of actual milieu therapy was severely limited, I hoped to deepen by understanding of the ward culture by participating in it as a patient".[2]

Although he makes some interesting suggestions about patient perceptions of staff behaviour and some useful comments about patient groups and subcultures he gets no closer to defining what it is about the milieu that has a therapeutic influence upon the patients, than he was before he started. In his conclusion for example, he states that "The degree to which there is a positive correspondence between the two (patient and staff ideals in regard to the treatment programme) might be taken as a partial indicator of the success of the treatment programme, but this demands systematic empirical study".[3]

It could be argued that Kjolseth's research strategy lacked sufficient connection between data, method and conclusions, since he fails to explain adequately how his participation as a 'patient' on the ward, especially for such a short period as 8 days, enabled him to understand the relationship

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1 Kjolseth R. Participant Observation on Patient Culture in a Therapeutic Milieu Setting. Journal of the Fort Logan Mental Health Centre, Vol.2 1964 pp.11-20.

2 Ibid P.11.

3 Ibid P.20.

between patient and staff assessments of the value of the 'milieu' in the treatment programme.

In the study of Woodside Villa, attempts were made to monitor both patient and staff assessments of the interaction between 'milieu' and treatment goals. A series of rating scales were used to complement the observed data deriving from participant observation. By combining both subjective observations and empirically structured data it was expected that a stronger link between data and research methods would be maintained.

The discussion of participant observation raises important questions concerning the role of the sociologist in psychiatric settings. Denman and Ruffin for example, have argued that "the sociologist who desires to take an active part in psychiatric milieu therapy must greatly modify the traditional role of his discipline*."[1] This 'applied' role seeks to enable the sociologist to become a 'contributing member of a multi-disciplinary therapeutic team", and "in as much as a therapeutic community is a society based on interactions, the sociologist's skills can be used to help the participants perceive the significance of their attitudes, behaviour and personality and how those factors affect the social structure".[2]

In earlier chapters, various other interpretations of the role of the sociologist in psychiatry were referred to in some detail. What becomes evident from this is the range of differing approaches to the study of psychiatric phenomena. The sociologist was variously described as an observer, information-provider, advisor, involved 'actor', systems analyst, expert on disease classification,[3] and team member.[4] Differences between

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1 Denman S.B., Ruffin W.C., The Sociologist's Contribution ot Milieu Therapy. Hospital and Community Psychiatry, 19, 1968, P.35.

2 Ibid P.36.

3 Figure 1 Chapter 3, Part 1.

4 Chapter 7, Part 3.

descriptions of modes of role playing reflect the kinds of disagreements that exist about questions of theoretical orientation. The sociologist, for example, who prefers the epidemiological study of psychiatric processes to the more direct attempts to establish aetiological links between overt behaviour and psychiatric disorders, will probably remain outside the therapeutic community hospital team one of whose stated ideals is to encourage the involvement of all professional members in the task of elucidating the processes that produce and alleviate disorders. Furthermore, the employment of empirical research techniques is not always appropriate to the situations in which the sociologist as team member finds himself. It is often the case that techniques are generated during the course of ongoing research when the personal involvement of the investigator is maximised. For these reasons the participant observer in a milieu therapy situation commences his study in the knowledge that his presence is itself an influential factor and, therefore, any analysis of his role must take into account the transactional nature of his relationships with the subjects of his research.

The framework upon which sociological research rests in the field of 'milieu therapy' and 'therapeutic community' is, therefore, tentative and subjective.

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CHAPTER 12

WOODSIDE VILLA : PRELIMINARY INVESTIGATIONS

1. Organisation

One of the first tasks undertaken by the researcher was an assessment of Woodside Villa's dependence upon the organisational structure of Shenley Hospital. (See Figure 7).

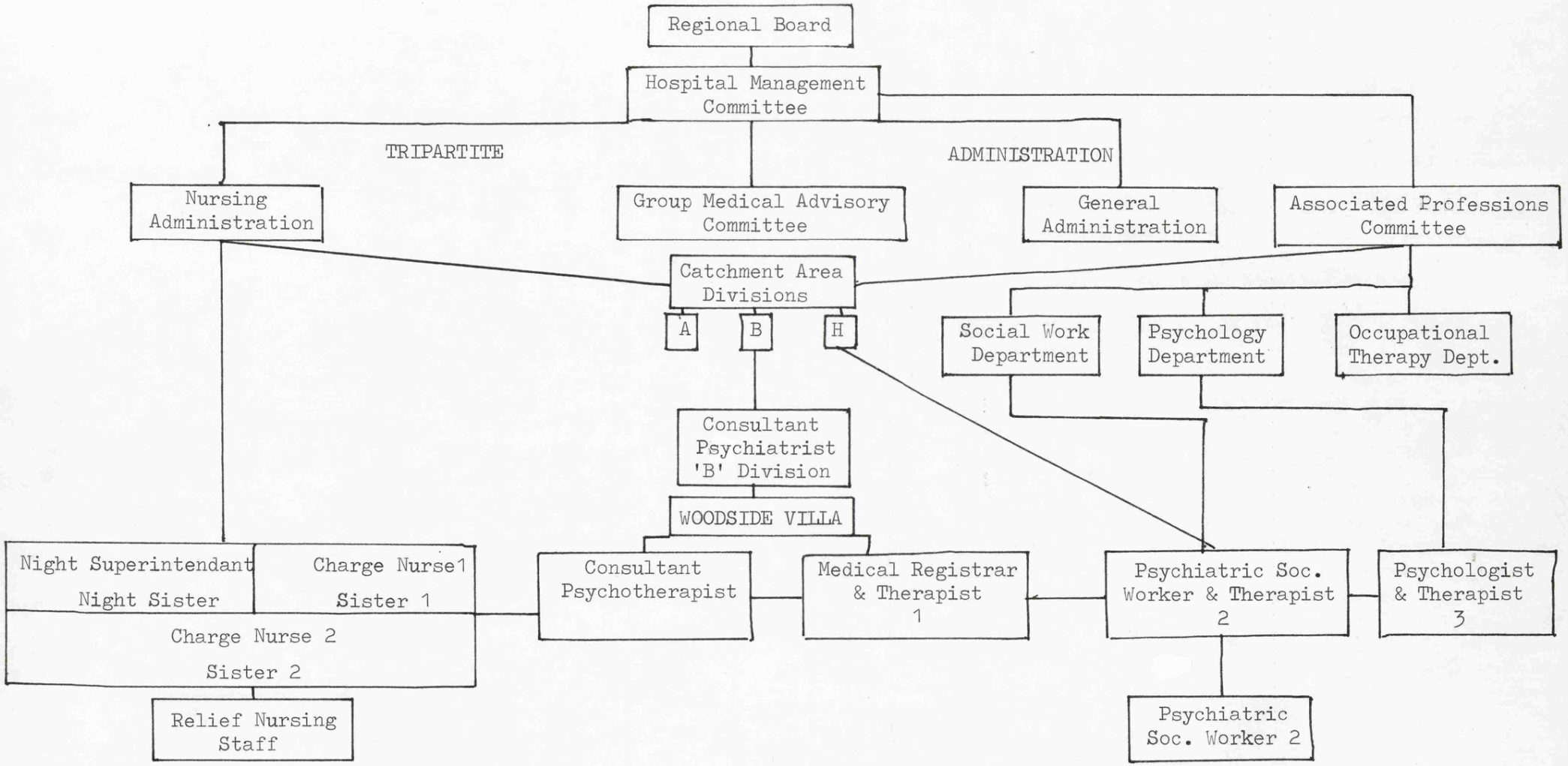
A 'horizontal' authority structure was evident within the Villa despite the fact that in dealings with external hospital departments medical and nursing roles adhered to the conventional 'vertical' pattern of authority. By horizontal, it is not implied that an 'egalitarian' structure existed, it stresses, instead, that open communications and joint consultation procedures were considered to be of primary importance to this special kind of ward community. It was fortunate that the four usual members of the nursing team held positions of equal seniority since this minimised the opportunity of using 'rank' as a means of asserting authority.

On questions of a medical nature the ward doctor made it clear to the researcher that he considered the opinions of his nursing staff to be of considerable value, particularly since their experiences on the ward were continuous and, therefore, well-informed, whereas due to his medical commitments in other parts of the hospital his own involvement at Woodside was often inconsistent. Administratively, Woodside relied upon the central hospital administration for staffing and most facilities, most noteable of which were food, general supplies and laundry.

Although, as was mentioned in a previous chapter, a degree of autonomy existed in matters of nursing staff selection, all nursing staff

FIGURE 7

Organisational Structure of Shenley Hospital with Reference to Woodside Villa (September 1971 - March 1972)



were subject to the policies of the nursing administration, which meant that staff could be withdrawn without special negotiation taking place in advance. An additional problem that was to become more evident to the researcher during his period of involvement at Woodside, was the short space of time that elapsed between the announcement that a staff member was going on a course, on holiday, or was leaving, and his or her actual date of departure. As will be shown in the ensuing discussion, these factors were probably responsible for much of the disturbance and internal disruption and uncertainty experienced by members of the community and can be said to have reflected the limited communication taking place between ward and nursing administration.

Medical policy within the Villa was determined by the ward registrar in consultation with the visiting consultant Psychotherapist and the divisional Consultant Psychiatrist. At the time, the latter Consultant was also Chairman of the Group Medical Advisory Committee, the body ultimately responsible for hospital medical policy. He was not ordinarily involved with matters at ward level, but was nevertheless the main link between the Villa and the central hospital administration.

Since it was not usual for divisional policy to deviate from hospital medical policy,[1] the possibility that Woodside might be seeking to develop in a direction not envisaged by the divisional consultant or the GMAC, may have accounted for the feeling amongst the staff that a form of latent control was being employed by the hospital administration to minimise the Villa's expected deviation from hospital medical policy. By 'latent' it is implied that controls were applied from outside the Villa, because negotiations between the Medical Registrar and the divisional

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[1] Shenley Hospital, Central Medical Office. Annual Figures, Significant Facts, 1969, P.5.

consultant never took place publicly, and yet staff and patients usually learned at some later date that certain projects or requests were not being sanctioned, or that changes were going to take place within the Villa for reasons known only to the two doctors. In such an atmosphere, it was not surprising that frustration was experienced by all parties, made worse by the fact that nobody really knew how much autonomy could be assumed by the community.

The therapists as well as the consultant psychotherapist who ran a once-weekly meeting, visited the Villa for the purpose of running psychotherapeutic groups. Their involvement in the general affairs of the ward was fairly limited. After the ward meetings on a Tuesday, an informal staff meeting would take place during which material arising from it as well as from the small groups would be discussed. Other such meetings took place informally when staff members requested that special issues concerning ward affairs be discussed. It was through these often spontaneous gatherings that an interest in 'milieu therapy' and 'therapeutic community' techniques began to develop.

2. Timetable of Events

The only 'organised' events taking place at Woodside Villa were meetings, of which four main types can be distinguished:

(i) Psychotherapeutic 'small' groups: held three times a week for the purpose of providing a psychotherapeutic experience for three different groups of patients. $1\frac{1}{4}$ - $1\frac{1}{2}$ hours duration.

(ii) The 'Tuesday Psychotherapy meeting': run by the visiting consultant psychotherapist for all the patients in the villa. 1 hour duration.

(iii) The 'Thursday General Meeting': a weekly ward meeting provided over by an elected patient 'council' for the discussion of matters concerning the life and style of the community. $1\frac{1}{2}$ hours duration.

(iv) Friday Staff Meeting : in which all staff connected with any aspect of work in the Villa met to discuss issues relating to the week from Friday to Friday. Approx. 1 hour duration.

It was pointed out to all patients that they were required to attend these meetings although no formal sanctions were taken against individuals who felt unable to keep to the routine. Unlike many 'established' therapeutic communities the 'community meeting' was held only once a week despite occasional attempts on the part of the Registrar to organise such meetings on a daily basis.

Apart from mealtimes, and the meetings shown on the Diagram 9, most other events were either spontaneous or were organised on a voluntary, flexible basis.

3. Meetings and Groups: Functions and Aims

(i) Psychotherapy in small groups

Three times a week groups of up to eight patients met with one of three therapists for an experience known as 'analytic group psychotherapy'. During the latter months of 1971, the two regular nursing sisters participated in the Doctor's and the Psychologist's groups and after the departure of the one sister her place was taken by a new female staff member of equal rank. The researcher joined the Psychiatric Social Worker's group after consultation with the patients and the therapist.

The purpose of these group sessions was twofold: firstly, they were designed to provide a psychoanalytically-oriented treatment experience for all patients and secondly, they endeavoured to foster relationships of a kind that could be built upon through co-operative activity within the Villa. Thus 'treatment', although specifically referring to the process taking place within these groups, could be generalised to include the

FIGURE 8

WOODSIDE VILLA : TIMETABLE OF WEEKLY EVENTS

	Psychotherapy Small Group 1 Registrar	Psychotherapy Small Group 2 Psychiatric Social Worker	Psychotherapy Small Group 3 Psychologist	General Psychotherapy Meeting	General Community Meeting	Staff (only) Meeting
Monday	0945 - 1100	0945 - 1100	0940 - 1100			
Tusday	NIL	NIL	NIL	0930 - 1030		1030 - 1100 (informal)
Wednesday	0945 - 1100	0945 - 1100	0940 - 1100			
Thursday	NIL	NIL	NIL		1000 - 1130	
Friday	0945 - 1100	0945 - 1100	0940 - 1100			1100 - 1200

continuing experiences of the patients within the community 'milieu'.

The Registrar explained on a number of occasions, that the special 'bond' or 'culture' which develops in the group analytic setting is the factor that uniquely separates the cathartic experience of psychotherapy from the social-interaction experience of the ward. In the former, personal awareness derives from the privacy of the transference situation, whereas in the latter social skills develop from participation as a member of a self-helping cooperative community.

The personal awareness - social skills dichotemy strikes a familiar chord. The reader may remember the views expressed by Edelson, Cumming and others in which it was suggested that participation in a special 'therapeutic milieu' involves a series of transactions through which the patient gains insight into his behaviour during the psychotherapeutic process and takes on new roles and tests their effectiveness through social interaction.[1] If one accepts Elaine Cumming's view that 'therapeutic community' and 'milieu therapy' strategies can be distinguished according to the extent to which they stress the importance of either group psychotherapeutic skills in conflict resolution, or means of improving the social performance of the patient,[2] then Woodside Villa would qualify as a 'therapeutic community', because of the very clear emphasis placed upon the interpretation of 'treatment' as the encouragement of personal intrapsychic integration.

The Registrar was further aware that the psychotherapeutic and sociotherapeutic endeavours required separate professional skills, which he explained as the joint use of psychotherapeutic, sociological and nursing roles. Trained therapists would provide the organisation to the group

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1 See Chapter 6, Part 2, pp 136-7

2 Cumming E. Therapeutic Community and Milieu Therapy Strategies can be distinguished Int. Journ. Psychiatry. 7, (4), 1969 pp.204-8.

therapy treatment enterprise, a sociologist would 'monitor' the developments taking place in the culture of the Villa and provide advice about ward social structure and patterns of interaction, whereas nursing staff would provide the teamwork around which the 'social' development of the community would centre. In order to understand the intimate connection between the 'treatment sessions' and the social life of the community, staff were, therefore, asked to consider joining one of the 'small' groups.

The kind of culture that this system created at Woodside was a cohesive blend of organised activity, feedback and informal discussion. The only possible weakness may have been the lack of communication between the psychotherapeutic groups, particularly since the patients, apart from in private informal conversation, had no means of knowing how each others experiences in their groups were reflected in their behaviour on the ward. It was not uncommon, for example, for patients at the community meetings to criticise the disturbed behaviour of one individual or group of individuals who may at that time have been undergoing difficulties in group management. Staff on the other hand had the benefit of being able to discuss what was going on in their groups, at the Friday staff meeting, or informally in the staff room. Unfortunately, due to the awkwardness of noting the contents of these groups during the staff meetings, the researcher was unable to gather data concerning the relationship between s small group and ward behaviour. This method was used however, in the examination of the other meetings.

It was possible on the other hand to note the variation in attendance figures for all the groups meetings and as a result of this it soon became

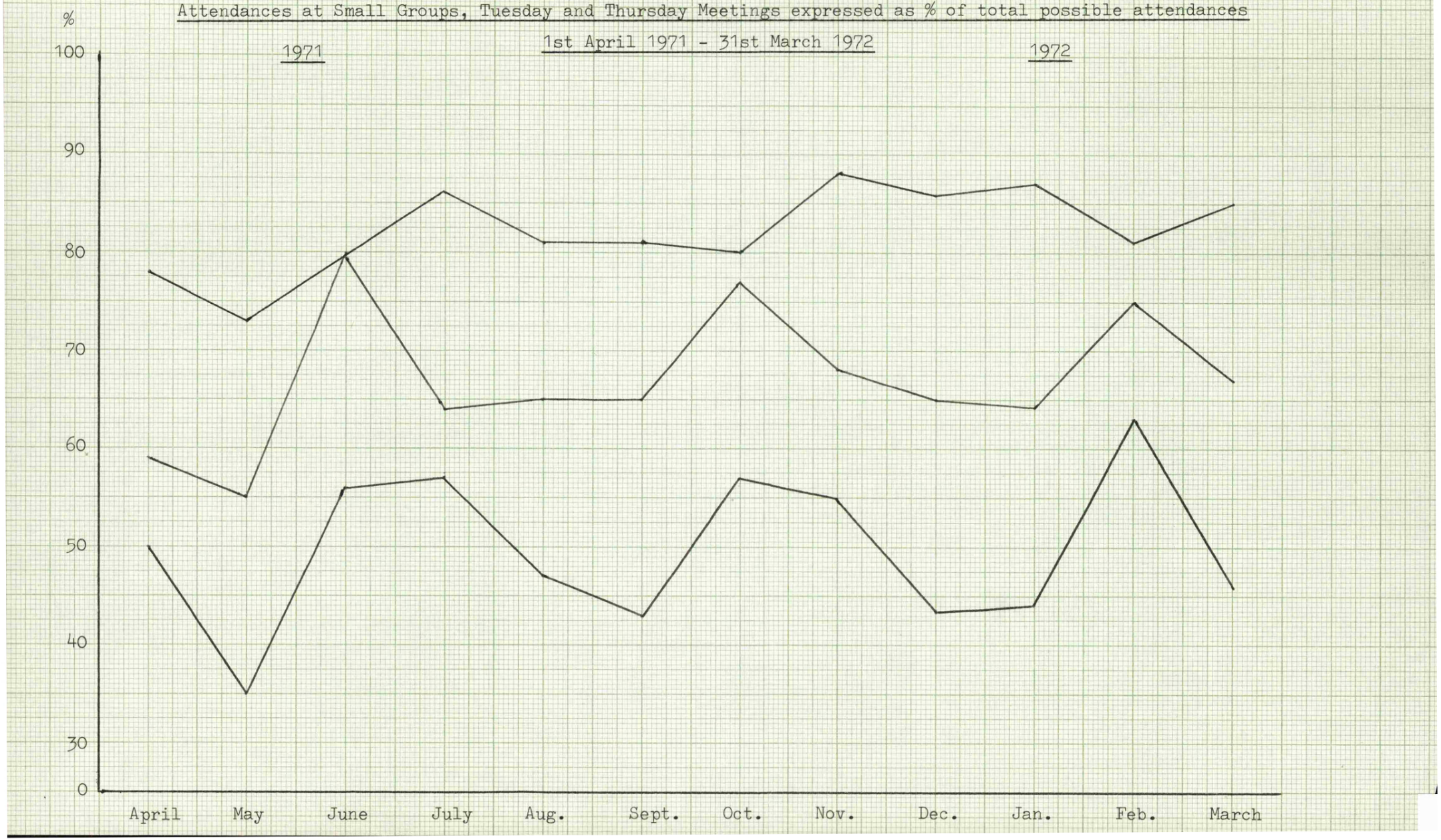
evident that (i) small groups were best attended of all the meetings, and more significantly, that (ii) the rise and fall in small group attendances appeared to be inversely related to the pattern of attendances for the Thursday General Meeting. Since, the latter meeting was generally viewed as an 'administrative' or 'practical affairs' session and the former groups as the main agencies of 'treatment', this inverse relationship seemed to suggest that where there was an unusually intense use of the psychotherapeutic facilities within the community, there was often a corresponding disinterest or rejection of the 'social' of sociotherapeutic machinery used by the community, and vice versa.

This same pattern was also noticeable in the relationship between small-group attendance, and attendance at the Tuesday general psychotherapeutic meeting. It was as if, at certain times, the visiting therapist would become the focus of the community's attention while the regular group therapists would experience a form of rejection. The following graph may help to illustrate these phenomena:

FIGURE 9

Attendances at Small Groups, Tuesday and Thursday Meetings expressed as % of total possible attendances

1st April 1971 - 31st March 1972



At the time when this part of the research was being carried out it was not possible to know whether fluctuations in meeting attendances were indicative of specific trends within the Villa. It seemed reasonable to hypothesise that observed variations in meeting numbers indicated changes in the 'mood' of the ward residents in response to events taking place both within and outside the Villa. What these 'events' actually were, however, was uncertain.

What became evident was the sharp decrease in all attendances during May 1971 followed by an even more noticeable increase in the two general meeting attendances during June. Then, as if to provide a show of faith in the psychotherapeutic treatment process, small group and Tuesday group attendances remained steady, while Thursday meeting attendances declined.

Admittedly, the general community meeting was usually better attended than its psychotherapeutic counterpart on a Tuesday, but it was pointed out by staff members that patients could be divided into regular and irregular attenders, the latter group opting out when prevailing circumstances least suited their needs. In other words, those who came and went as the emotional climate of the Villa changed, behaved as a kind of barometer for the community. As time went by, the researcher saw how this rather general observation, in fact, reflected important aspects of ward morale and group culture.

Having established that meeting attendances fluctuated considerably between April and August 1971, the researcher began to look for other sources of information that could provide the background to the ward situation. The information was quickly found in the nursing staff's ward reports covering the 24 hour day-to-day situation of life in the Villa. These 'reports' were to prove to be valuable sources when combined with the information gained through small group participation, for together they

provided the link between the 'treatment' situation and the 'social' situation at Woodside.

Taking as an example the period of four weeks during April 1971 the ward reports cite the following incidents:-

		M = Male F = Female
2/4/71	F smashed ward furniture, crockery	M
4/4/71	F continual smashing up	M
6/4/71	K restless, very agitated	M
6/4/71	P creating noisy disturbance at night	F
10/4/71	J withdrawn, solitary, unresponsive	M
10/4/71	P & J fighting	F
12/4/71	J still withdrawn, solitary	M
16/4/71	F abusive, drunk, insulting to female patients	M
17/4/71	P drunk, smashing crockery, abusive	F
20/4/71	R very agitated over mother dying	M
22/4/71	J still solitary, withdrawn	M
22/4/71	PG drunk, injured in own room	F
23/4/71	F drunk, abusive, removed to locked ward	M
25/4/71	F drunk, abusive	M
26/4/71	J still solitary, withdrawn	M
26/4/71	L Hysterically upset	F
27/4/74	F hysterical, demanding behaviour	M
27/4/71	F hysterical, demanding removed to locked ward	M
29/4/71	F hysterical, demanding	M
1/5/71	L absent from ward/AWOL	F

Of the twenty incidents reported, seven involving violence and the more extreme forms of behaviour were ascribed to one severely disturbed patient who later discharged himself from the Villa. Four other incidents

were ascribed to one female patient who again was experiencing bouts of extreme agitation, and four mentions are made to 'J' who remained totally isolated from the rest of the community throughout the month. This anxiety-depression cycle dominates the month of April to May, in which attendance at all groups and meetings falls sharply.

During a discussion with the medical registrar at a later date the researcher was able to gain some insight into the occurrences mentioned above. It appeared that due to uncertainties amongst staff and members of the community, insufficient action had been taken by the various responsible members of the community to deal with the spiralling violence and anxiety. The result was that patients began to feel more insecure; began to doubt the authority of staff in dealing with such problems and started opting out of all formal activities as if to say 'you can't help me'. As the group psychotherapy process was rejected, the social structure of the Villa began to feel the effects of dislocation. This 'chain reaction' or 'cycle' resulted in a devaluation of both the 'sociotherapeutic' and 'psychotherapeutic' functions of the community only to resolve itself through the restoration of confidence in the staff's ability to contain the situation.

Behavioural phenomena of this kind have been observed on a number of occasions in other psychiatric settings. Stanton and Schwartz, for example, documented cases of pathological excitement in patients who were the subjects of covert staff disagreement about management,[1] and Bradshaw has documented a similar case of the 'Stanton-Schwartz effect' in which hidden racial tensions amongst staff on an American psychiatric hospital

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[1] Stanton A.H., Schwartz M.S. The Mental Hospital. Basic Books, N.Y. 1954.

ward were brought to light after a series of incidents involving patients and junior nursing staff.[1] In both cases, the inability of the staff to deal openly with their own problems resulted in a destructive situation in which the patient group were the unfortunate victims.

This brief review of the existing situation at Woodside Villa suggested that problems of adaptation to a new style of working in a psychiatric ward contributed towards misunderstandings and disagreements between staff with the result that patient confidence in the security of the ward milieu was, from time to time lacking and thereby contributing towards anxiety and disturbed behaviour. The fact that all aspects of the treatment programme became subject to these events seemed to suggest that communication between visiting therapists and ward staff (during the period April to August 1971) was lacking in some way and required elucidation. On the basis of these preliminary investigations certain ideas for collecting relevant data began to emerge. These will be discussed further after reviewing the functions of the other meetings.

2. The Thursday General Meeting

'General' or 'community' meetings in therapeutic communities are often regarded as the focal point of the day on which they occur, because they function as corporate decision-making bodies from which ward policy derives and out of which, the culture of the community develops. Clark, for example, says of the 'community meeting' that "This is the main forum for most of these processes (freeing of communications, analysis of events, provision of learning experiences, flattening of the authority pyramid, role examination) and is often considered the main characteristic of the therapeutic community".[2]

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1 Bradshaw W.H. The Coffee Pot Affair : An Episode in the Life of a Therapeutic Community. Hosp. & Comm. Psychiatry Feb. 1972 pp.17-22.

2 Clark D.H. Administrative Therapy: The Role of the Doctor in the Therapeutic Community. Tavistock 1964, P.46.

Martin's early therapeutic community experiments of Claybury Hospital operated a twice weekly community meeting structure which were large in numbers and informal in organisation. He states that "The primary function of the (community) meeting is to open communications between staff and patients as freely and fully as possible",[1] and includes all working staff seated in a circular organisation designed to prevent patients from hiding and from isolating themselves from Staff. "The meetings", he continues, "are thus treated as psychotherapeutic groups and interpretations made in terms of the interrelationships and emotional conflicts within the group".[2]

On the question of the frequency of such meetings, he states that "It is of course better to meet once or twice a week than not at all, but the daily meeting is the most effective"... mainly because... "If there is a long interval between one meeting and the next, important emotional events will have been forgotten or covered up. The meetings will (therefore) take much longer to 'warm up' to the discussion and much valuable therapeutic material will be lost..."[3] Success or failure of these meetings was thought to depend upon the degree of 'real' freedom permitted, that is, where the attitudes of ward staff are neither authoritarian, aggressive, evasive or defensive.

Clearly, the community meeting is seen to be an important and valuable factor in the life of a 'therapeutic community'. There are, however, differences in the nature, style and purpose of such meetings. Whereas Martin, for example, speaks of the 'psychotherapeutic' function of the general meeting, at Woodside Villa, the Thursday meeting began its life as

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1 Martin D.V. Adventure in Psychiatry. Bruno Cassirer. Faber 1962, P.52

2 Ibid P.53

3 Ibid P.55

an administrative session during which the practical affairs of the community were discussed. It is true that as an aspect of the wider 'supportive' milieu, this meeting served as an adjunct to the psychotherapy enterprise, but it was not viewed as part of 'treatment' in the strict sense of the term.

The Thursday meeting, which took place for $1\frac{1}{2}$ hours during the morning, was an important event in the community's week. It was the only time when all ward staff joined the patients to discuss general affairs. Significantly, it was the only meeting in which the Registrar met the total patient group, since in all other groups, therapists or ward staff took over management responsibility. For this reason it was not surprising that patients sought on occasion to use meeting time for matters other than simple administrative issues.

When it became evident that the psychotherapy groups were not always being used to their full potential it was observed that the general meeting would begin to take on the characteristics of a substitute for the more organised psychotherapeutic meetings. It may have been that the Registrar was being persuaded to act as 'therapist' to the whole community on occasions such as these, particularly where patients' attempts to resolve emotional difficulties extended beyond the boundaries of their own groups.

This observation combined with those mentioned in the previous section on 'small groups' prompted the researcher to make detailed notes of everything taking place in the community meetings with the eventual aim of being able to develop a means of evaluating verbal contents from which links could be established between (i) meeting attendances (ii) ward behaviour and (iii) the changing 'culture' of the community.

As will be shown in due course, this method of data collections proved to be of great value in that it provided some sort of direction for further study.

One of the main difficulties encountered in participant observation studies is that one can never know at the time whether a series of events occur at random or are part of an emerging trend. It is easy in retrospect to say that 'the researcher saw .x. developing' when, in fact, he may only have been aware of a random series of events and not a progression of inter-related phenomena. This problem was encountered during the early stages of work at Woodside Villa. All that could be assumed at the time was that certain verbal references to a type of 'milieu therapy' organisation were being made, such as those referring to the consensual decision making structure, the 'liberalised' staff-patient rapport, the sharing of amenities on the ward, the use of meetings as a means of improving communications and the linking of treatment sessions to the social life of the community. Later, as the researcher's interests became better known to the ward staff spontaneous discussion of and about therapeutic community principles and methods to take place.

The Registrar, for example, circulated amongst the staff, an account by a doctor at a neighbouring hospital, of the setting up and management of a 'therapeutic community' on an acute admission ward. On another occasion, during an informal conversation in the staffroom, he mentioned that over the previous 9 months he had come to realise that there should 'be greater consistency in treatment practices in the Villa', meaning that the experiences of small group psychotherapy should be related more meaningfully to the community meetings for 'the benefit of the patients'. It was from simple beginnings such as these that the researcher was able to visualise some kind of framework for the collection of evaluative information.

The interchangeable participation of patients in groups and meetings reflected changes in ward morale, and where allegiances to therapists or community leaders changed, it began to emerge that meetings were substitutes for groups and vice versa, and large scale non-attendance was indicative of dissatisfaction with modes of organised activity. What now remained for the researcher was the task of discerning the underlying reasons for the changes.

3. The Tuesday Psychotherapy Meeting

Whether, as Martin suggests, large community meetings can be termed 'psychotherapeutic groups' in a matter open to interpretation, particularly since the distinction between 'milieu therapy', 'therapeutic community', and 'community group living', is as yet unclear.[1] It is widely believed that 'milieu therapy' and 'therapeutic community' refer to secondary, supportive treatment enterprises and that within these settings the primary agent of treatment is psychotherapy. The distinction centres on the question of whether 'treatment' concerns methods of improving intrapsychic integration as compared with resocialisation techniques and the development of social skills.

The 'Tuesday psychotherapy meeting' at Woodside Villa was without doubt, an example of a 'large therapeutic group', run by the visiting Consultant Psychotherapist. Of all the meetings held on the ward, this one had the poorest attendance record, ranging between 35% and 60% over the period April 1971 to April 1972. The function of this meeting was to provide a psychotherapeutic experience for the entire community, thus complementing the work being carried out in the small groups.

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[1] Curry A.E. Large Therapeutic Groups: A critique and appraisal of Selected Literature. Int. Journal of Group Psychotherapy, 17, (4) 1967 pp.536-547.

Unlike the Thursday General Meeting, the Tuesday group was composed of the Therapist and ward staff, the Researcher and as many patients as had decided to come, all seated around the sides of the long dining room. A formal analytic group procedure was acknowledged whereby the Therapist refrained from speaking or introducing any theme that might direct the course of discussion. After initial silences, the meetings generally turned to issues concerning the emotional life of the community.

One of the early observations made by the researcher concerned the manner in which attendances at this meeting seemed to reflect the prevailing 'mood' of the community. The graph on page 300 shows how attendances at the Tuesday and Thursday meetings follow a similar pattern, yet are often inversely related to attendances at the small groups. At each point where small groups attendances show a definite fall (e.g. October 1971, February 1972; excluding May 1971 which was due to a special set of circumstances) interest in the Tuesday meeting increases, which suggests that the 'community psychotherapy meeting' was either (i) used as a substitute therapy session, or (ii) as an adjunctive session when problems concerning relationships <u>within the community</u> outweighed individual problems.

These observations raised the question of whether certain meetings were being used specifically for the resolution of 'community' as distinct from 'individual' problems. If so, it would be possible to establish from both observed and reported data when social isolation and fragmentation in the Villa gave way to community concern and corporate responsibility, and to what extent these meetings provided the means through which members of the community identified as a group.

By keeping track of what was being written in the nursing ward reports, the researcher was able to establish links between the <u>reported</u> behaviour of members of the community and <u>observations</u> of this behaviour made during

the course of his involvement in the Villa. Graphs for example, were developed to provide visual information of day-to-day changes. Gradually, information began to accumulate showing how two main behavioural themes; (i) anxiety and (ii) depression, characterised the atmosphere of the ward throughout its twenty-four hour cycle. The findings of these graphs will be described in the following chapter.

Conclusions

Preliminary investigations at Woodside Villa during the first few months of the researcher's involvement revealed that: (i) the psychotherapy enterprise was the primary agent of treatment, and the social experience of participating in a supportive milieu was viewed as the secondary, or socio-therapeutic agent. (ii) Defined in the above manner, Woodside Villa was viewed as a 'psychotherapeutic community' because the analytic treatment approach provided the framework around which the culture of the ward was based. For this reason, less emphasis was placed upon some of the more conventional aspects of 'therapeutic community' practice such as 'democratic' procedures, or 'reality confrontation' methods. (iii) The inverse relationship between attendance figures for the psychotherapeutic small groups and the Thursday 'general' or 'community' meeting, as well as for the Tuesday psychotherapy meeting seemed to point to the operation of a substitution effect whereby (a) questions concerning evaluative matters such as emotional tensions within the community, which would normally be dealt with in the privacy of small groups, would be transferred to the Tuesday meeting under the authority of the consultant psychotherapist, or where (b) discussion of such issues would be dropped and interest be taken in administrative or external matters during the Thursday general meeting, when the ward registrar was present.

(iv) The above observations seemed to point to three dominant themes characteristic of all the meetings. These were (a) evaluative matters, (b) administrative concerns (c) external or extra-mural concerns. Where a substitution effect was thought to be in operation it could be hypothesised that changes in the content and attendance of significant meetings would be accompanied by changes in the behavioural pattern of the ward identifiable through alterations to the graph monitoring behavioural changes in the community.

(v) At those times when the psychotherapeutic small groups were being least well attended it seemed that tensions within the ward were often at their highest, leading the researcher to hypothesise that there was an inverse relationship between lack of support for the psychotherapy treatment enterprise and social fragmentation (or a lack of 'community identity') within the villa.

In the next chapter the methods adopted by the researcher for examining the validity or falsity of these observations and hypotheses will be described, followed by a summary of the findings of each research technique.

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CHAPTER 13

WOODSIDE VILLA: RETROSPECTIVE ANALYSIS

This chapter is intended to explain the development of a number of techniques of data collection used at Woodside Villa and how they helped to generate new ideas from qualitative information. Preliminary investigations showed that 'treatment' was intimately connected with the socio-therapeutic environment of the ward, although very little understanding of the interaction between the two was evident. After careful observation it had become fairly clear that the emotional climate of the ward was extremely volatile, and yet links between behavioural changes and specific ward situations were not easily identifiable.

Matters such as these were considered to be of importance to the staff team since disequilibrium on the ward could be interpreted by those outside as a poor example of therapeutic effectiveness, particularly since criteria of success in treatment within the Villa differed sharply from criteria adopted by doctors in other parts of the hospital. Furthermore, with an average length of stay on the ward of 16 months,[1] critics of Woodside's psychotherapeutic treatment policy did not require alternative sources of evidence before talk of 'chronicity' and failure found expression.

Woodside Villa gave the impression of developing into the kind of organisation known as a 'therapeutic community'. The fact that the ward was significantly 'different' in terms of therapeutic organisation from other wards in the hospital seemed to lend weight to such a belief.

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[1] Estimated from admission and discharge statistics Jan. 1971 - February 1972. (Range : 3 months - 5 years).

The Registrar was concerned, however, to elucidate the factors making for a systematic understanding of the combined uses of psychotherapy and 'sociotherapy' on the ward. It was for this reason that he viewed the role of the sociologist as that of the informed participant rather than external observer.

1. Observed Data : Graphical Measures

(i) Ward Behavioural Graph

In the last chapter it was explained that observations of changes in the mood and behaviour of patients on the ward had indicated that such variations were responses to identifiable situations. It had been discovered that the key to many of the disturbances taking place on the ward could be found in the daily nursing ward reports, which gave brief accounts of all occurrences taking place throughout the twenty-four hour period.

Following initial discussions with staff about the information contained in these reports, the researcher began to rank (in order of significance) all of the main entries, as a means of classification from which a graphical axis could be determined.

The following list of behavioural categories derives from a series of assessments of the information contained in the ward reports; they have been ascribed values of between 1 and 10 on a 'serious-least serious' scale.

FIGURE 10

Item Rating by Staff for the Ward Behavioural Graph

Serious

1. Attempted Suicide/Drug overdose.
2. Self inflicted injury/Threat of Suicide (genuine)
3. Expression of intent to harm others/discharge against medical advice/Restriction of movement to ward only/expression of of suicidal feelings.
4. Attacking another patient(s)/stealing.
5. Smashing objects/physically aggressive behaviour.
6. Hysterical, Aggressive, abusive behaviour/Threat of autonomous discharge.
7. Being discovered in bed with another patient/Over-extending sexual license.
8. Being involved with police or formal authority figures outside Villa.
9. Disturbing at night/Being found drunk or acting in a disorderly manner.
10. Absent without leave/being solitary, withdrawn/anxious, tearful, depressed/demanding.

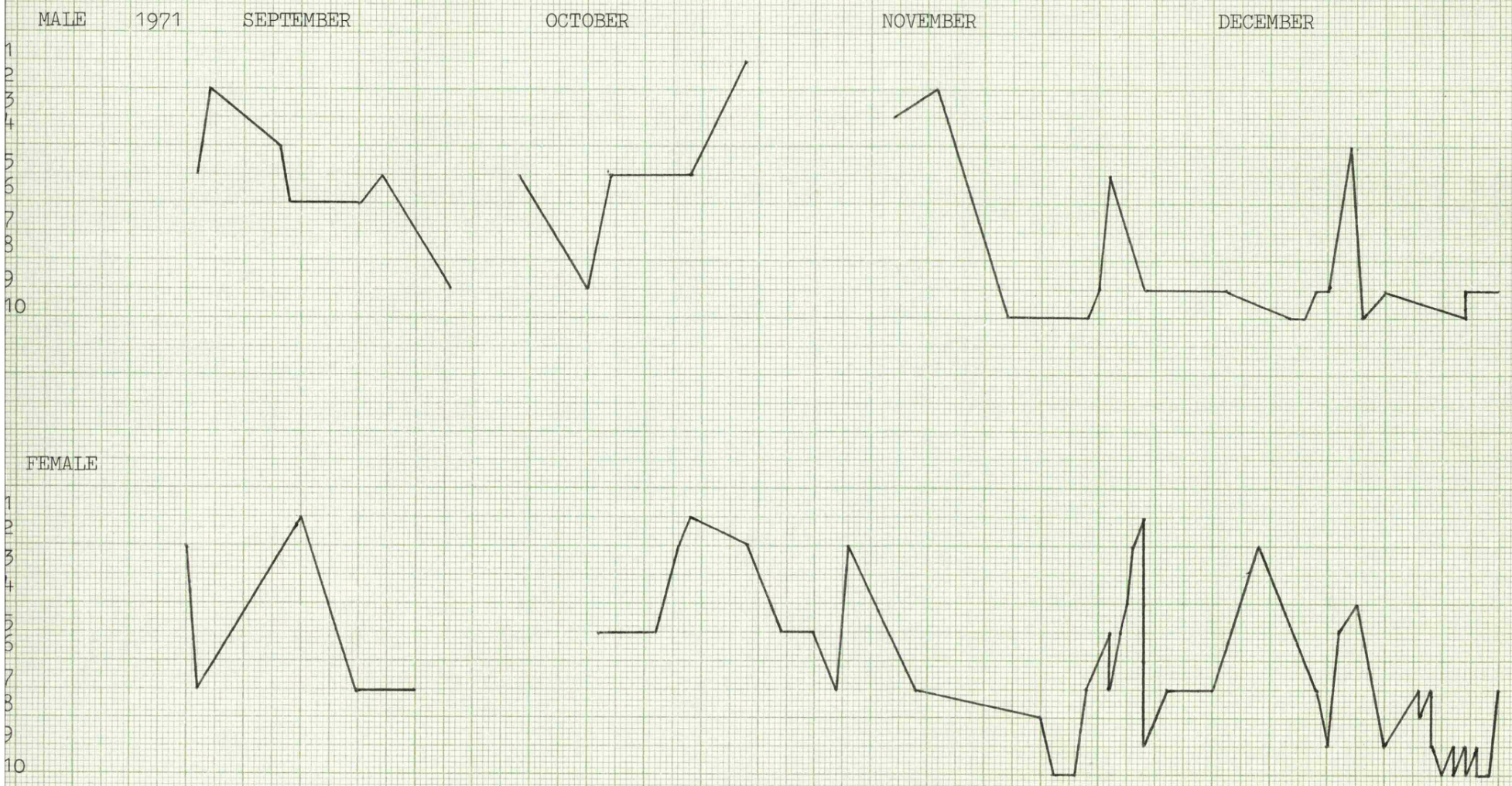
Least Serious

Having established the order of importance of the items in ward reports it was then a relatively simple task to draw a graph showing daily alterations in patterns of behaviour on the ward. Figure 11 shows the kinds of variations experienced by the community over a period of 10 months.

FIGURE 11

Graph showing the incidence of ten specified types of behaviour at Woodside Villa

September 1971 - June 1972



SOURCES: Behavioural items 1-10 from Figure 10, "Item rating by staff for the Ward behavioural graph".
Daily events recorded in the Ward Reports and extracted from these for the graph.

FUGURE 11 (cont'd)

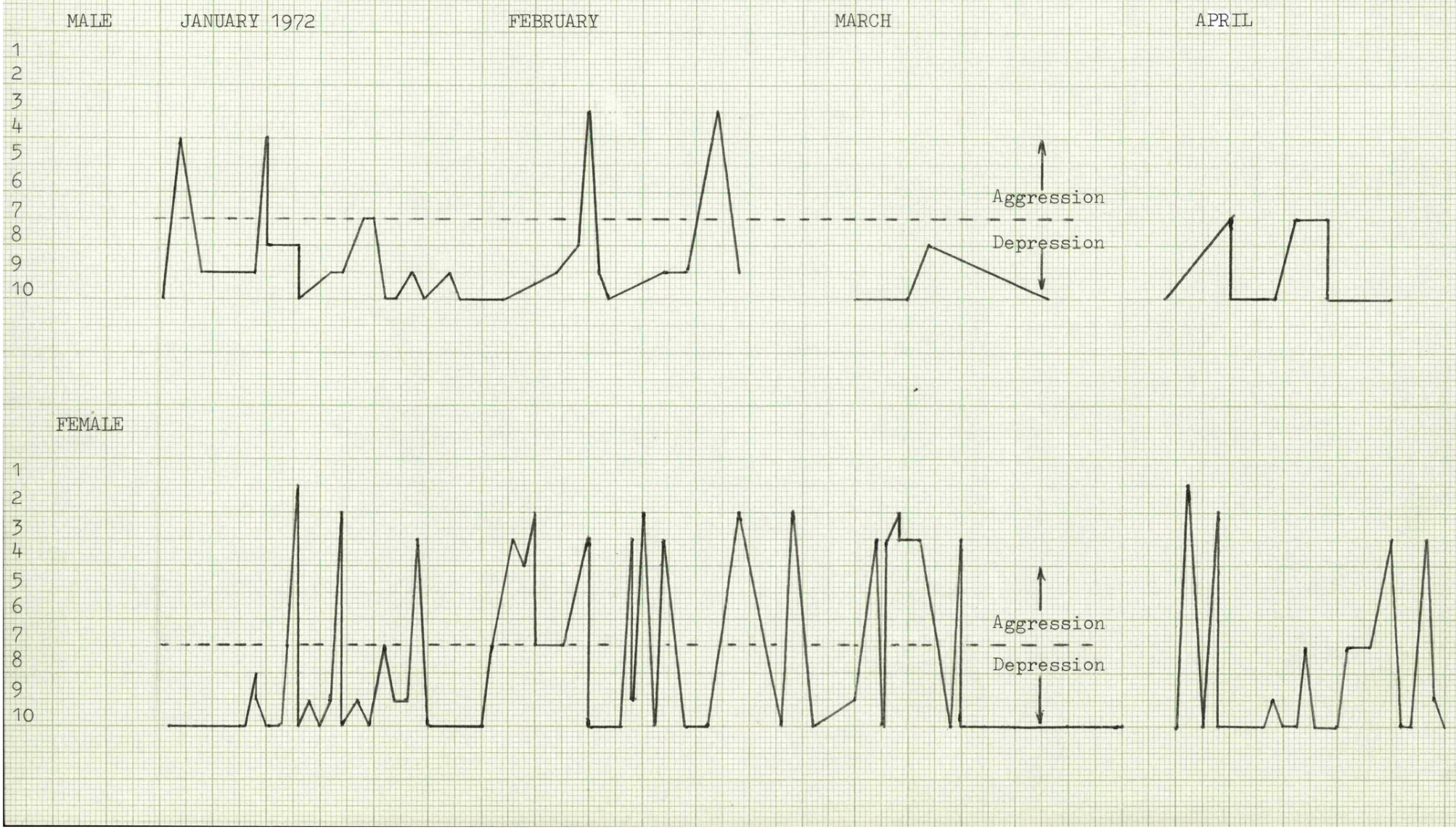


FIGURE 11 (Cont'd)

It should be stressed that the very considerable increase in the incidence of certain modes of behaviour reported after October, 1971 may have been due partly to an improvement in the reporting of events consequent upon the greater emphasis placed on the need for 'feedback' in the community. It is nevertheless, clear that events taking place in the Villa over the period September 1971 until June 1972 were of sufficient magnitude to have (1) led to an increase in the incidence of disturbed, destructive or depressive behaviour, and to have (2) resulted in a wider variation of such behaviours than was previously evident.

The 'female' graph shows a marked increase in the more anxiety-induced modes of behaviour, particularly during the period November 1971 to May 1972, whereas over the same period, the 'male' graph shows, if anything, a retreat into depressive behaviour, characteristic of non-involvement or isolation. These two markedly different modes of expression give the impression that the women had a tendency to express feelings of anxiety or uncertainty in a more physically and verbally destructive manner than their male counterparts.

Often, when referring back to the ward reports it was found that male-female 'couples' were thought to influence each others behaviour, and on occasions, acute periods of disturbance involving one or two males would set off a chain reaction during which the female patients would react in a more overtly self-destructive or provocative manner. Why this should have been the case was not immediately obvious to either the staff team or the researcher. It was possible to ascribe responsibility for certain kinds of disturbance to 'manipulative' or 'hysterical' patients, but this involved diagnostic stereotyping that was not in keeping with the philosophy underlying the general approach to treatment. Had selection by diagnostic type been an accepted principle upon which the treatment programme was based,

different criteria would have been adopted in questions of patient improvement, responsibility towards the community and so forth.

What was now required was information about key events taking place over the period covered by the graph, so that suggestions could be made concerning related causes and effects.

Due to the absence of recorded data prior to September 1971, it was not possible to establish any links between ward behaviour and external events, except for July of that year when two suicides within the hospital are thought to have led to disturbance amongst Woodside patients. From September 1971 until June 1972 the researcher was able to record the following events, most of which, as it turned out, concerned the movements of key staff, within and outside the Villa. Figure 12 describes the main events noted during these nine months.

FIGURE 12

Special Events taking place at Woodside Villa, September 1971 - June 1972

September 1971

1. Senior charge nurse and Therapist leaves Villa at short notice - disagreement evident.
2. Registrar and consultant Psychotherapist in covert disagreement over therapeutic policy.
3. Arrival of researcher.

October 1971

1. New charge nurse starts (JM).
2. Registrar on 3 week holiday.
3. Continuous mention of need to 'restructure' Villa.
4. Nursing Sister on extended leave.

November, 1971

1. Registrar announces impending departure from Villa after 3 years.
2. Autonomous patient discharges/influx of new patients.

December, 1971

1. Christmas: Registrar leaves Villa.

January 1972

1. New Registrar starts. Appears to adhere to a less psychotherapeutic approach to treatment; Psychopharmacological orientation.
2. Senior nursing sister leaves after three years.
3. Admission of severely disturbed female patient.
4. Angry, sometimes violent confrontations between three patients.
5. Male patient very aggressive/destructive during meetings.
6. Severe electric storms giving rise to anxiety.

February 1972

1. New charge nurse (JM) leaves for 4 week course.
2. Large changeover of ward staff due to absences, etc.
3. The more overtly 'psychotic' patients particularly disturbed, agitated.
4. Usually solitary, withdrawn male (senior) patient (J) very active in ward affairs.

March 1972

1. New nursing sister starts.
2. Charge nurse returns from course.
3. Patient J once again solitary and withdrawn.
4. Researcher announces departure (formally).

April 1972

1. Registrar announces impending departure.
2. Therapist (JL) announces impending departure.
3. Charge Nurse (JM) on holiday.
4. Charge Nurse (JD) on course.

May 1972

1. Frequent staff changes; junior nursing staff on ward.
2. Usually withdrawn female patient disturbed following change in medication.

June 1972

1. Registrar leaves Villa.
2. New registrar (female) starts. Analytical orientation.

The graph reveals that from the end of November, 1971 the incidence of, in particular, disturbed behaviour, increased considerably with only a temporary respite during the second half of March, 1972. The announcement during the Thursday General Meeting of November 4th 1971 that the Registrar would be leaving the Villa at the end of December precedes a two-week period of depression (see graph: the downward trend from the 4th until the 24th November shows that (i) fewer incidents were reported (ii) of those reported, most were of the depressed, withdrawn type, or incidents in which patients were involved outside the Villa, followed by a continuous build-up of unsettled, agitated behaviour. The loss of the doctor around whom the culture of the ward had developed, was interpreted by the community as a threat to security. Furthermore, this event followed in the wake of another disturbing event - the departure in September of one of the Senior Charge Nurses who had also been a therapist in the Villa.

The latter's departure was announced only days before he left the Villa leaving a feeling that something had taken place within the staff group that had not been made known to the community. His replacement was also left unannounced to the community mainly because appointments to the ward were carried out externally, through the central nursing administration. Events such as these did not appear to be dealt with at an early stage by the whole community which implied that either (i) they were not seen to involve, or be the responsibility of the patients at Woodside, or (ii) there genuinely was no control over departures and replacements, hence joint consultation was fairly irrelevant.

Between September 1971 and June 1972 there were 16 occasions on which staff left the Villa permanently or temporarily, of which three involved changes of medical registrar, (prior to which there had been no changes in three years)two, changes in senior nursing staff and two in which junior nursing staff, unfamiliar with the way in which Woodside was run, took the place of regular staff who were on courses or on holiday. These events followed a two year period during which major changes in staffing were rare, therefore, it seems fair to argue that an increase in the number of departures and replacements would have had an unsettling effect upon the ward.

The second most noticeable feature on the graph is the difference between male and female behaviour patterns, <u>in response to the same general situations</u>. If a line is drawn through level 7 on the graph, it can be seen that references to the behaviour of male patients are almost entirely of the kinds mentioned in items 7-10 in Figure 10 (P.315) with a few noteable exceptions, whereas references to the behaviour of female patients are to a far greater extent of the kinds represented in items 1-6. Assuming that items 1-6 are associated with the overt expression of anxiety

through physical and verbal aggression directed at self and others, and items 7-10 are associated more with avoidance, withdrawal, escape, depression or the more covert examples of aggression towards the community (such as lack of participation, angry silence, disturbance at night) then it can be argued that in response to increasing insecurity on the ward women tended to express anxiety through overt aggressive behaviour whereas men expressed it through avoidance behaviour and depression.

The question of the departure of key members of staff from a community has not been completely ignored in the literature. Esquibel and Kort,[1] for example, in an American study, state that "The departure of a meaningful member of a therapeutic community creates 'vacua' which must be "enveloped", to borrow from (Maxwell) Jones' terminology. His departure produces many realistic as well as psychological stresses in the therapeutic community, especially if this community, due to the common problem of inadequate professional staffing, has come to rely heavily on this individual".[1]

Instead of announcing his intentions to depart at a point very close to the actual date of departure, the doctor in question proposed a 90-day period during which special group activities were to be encouraged through which he could participate for increasingly shorter periods of time, with the aim of 'phasing himself out of the community'. Although reaction to his leaving took the forms of anxiety, verbal criticism and behavioural disturbance, the authors conclude that 'structured separation' is not only an effective way of offering "a more stable, manageable post-separation period" but could also be "effectively utilised in therapeutic communities and other organisations".

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[1] Esquibel E.V., Kort G., Structured Separtion of a Key Physician from a Therapeutic Community. Intern. Journ. of Group Psychotherapy, 1969, 19, 4 pp.448-453.

In the case of the first doctor's departure from Woodside Villa only two month's notice was given to the community, despite the fact that it had been rumoured that he would be leaving by the end of 1971. Unlike Esquibel and Kort's situation, Woodside's registrar was able to offer the community little opportunity of a 'structured' separation because there were no other doctors available to take his place. On his departure therefore, the sense of loss to the community was marked, and due to the uncertainty over his replacement a greater incidence of disturbed behaviour amongst patients was recorded in the ward reports.

The graph suggests that the departure of this Registrar was not the only occasion to be followed by markedly different patterns of behaviour amongst the patient population. Throughout the entire period of 7 months following the Registrar's announcement of his departure, changes in staff on the ward were both preceded and followed by disruptive or depressive behaviour. This trend suggests that inconsistencies in staffing policy, combined with a lack of understanding of the effects upon the patient population of continuous staff changes may have played a significant role in the creation of anxiety and disturbed behaviour.

The value of the behavioural graph lies in its simplicity. Although it is not an accurate measure of any given group of phenomena it nevertheless facilitates the collection of information on a daily basis and thereby functions as a monitor of behavioural trends.

(ii) Evaluation of the Contents of the Thursday Meeting

In the previous chapter it was suggested that patients might have used the various meetings as 'substitutes' for each other, particularly during times of uncertainty when emotional problems were not being resolved in the psychotherapeutic groups.

The attendance graph (Fig.9), appeared to suggest that (a) attendances at the Thursday General Meeting increased as attendances at psychotherapeutic groups decreased and the Ward Behaviour Graph (Fig.11) appeared to suggest there was (b) a direct relationship between lack of support for the psychotherapy enterprise and social fragmentation in the Villa. If these observations were correct it could be argued that an essential aspect of the machinery of this 'therapeutic community', i.e. the meeting structure, was not functioning adequately, since containment of anxiety at a personal level was the primary task of the psychotherapy groups, and at a 'community' level it was the task of the Tuesday psychotherapy meeting and the Thursday general meeting.

As a means of testing whether or not a 'substitution effect' was taking place along the lines suggested by the graphs, a method of assessing the variable contents of the Thursday meeting was devised in consultation with the staff of the Villa. On the assumption that 'evaluative' concerns would take up more of the meeting's time when support for the psychotherapy enterprise was on the decline, a simple method of coding discussion subjects was arrived at. Three themes appeared to characterise the contents of the meetings, (1) administrative issues, (2) evaluative concerns, and (3) extra-mural matters. The system of coding was fairly arbitrary due to the fact that a number of discussion topics involved aspects of each of the three themes. The following list is an example taken from meeting notes for February 1971 and may help to illustrate the general system;

FIGURE 13

Example of Coding Procedure for the Contents of Thursday General Meeting

February, 1971

Number of Meetings Held in February 1971 = 3

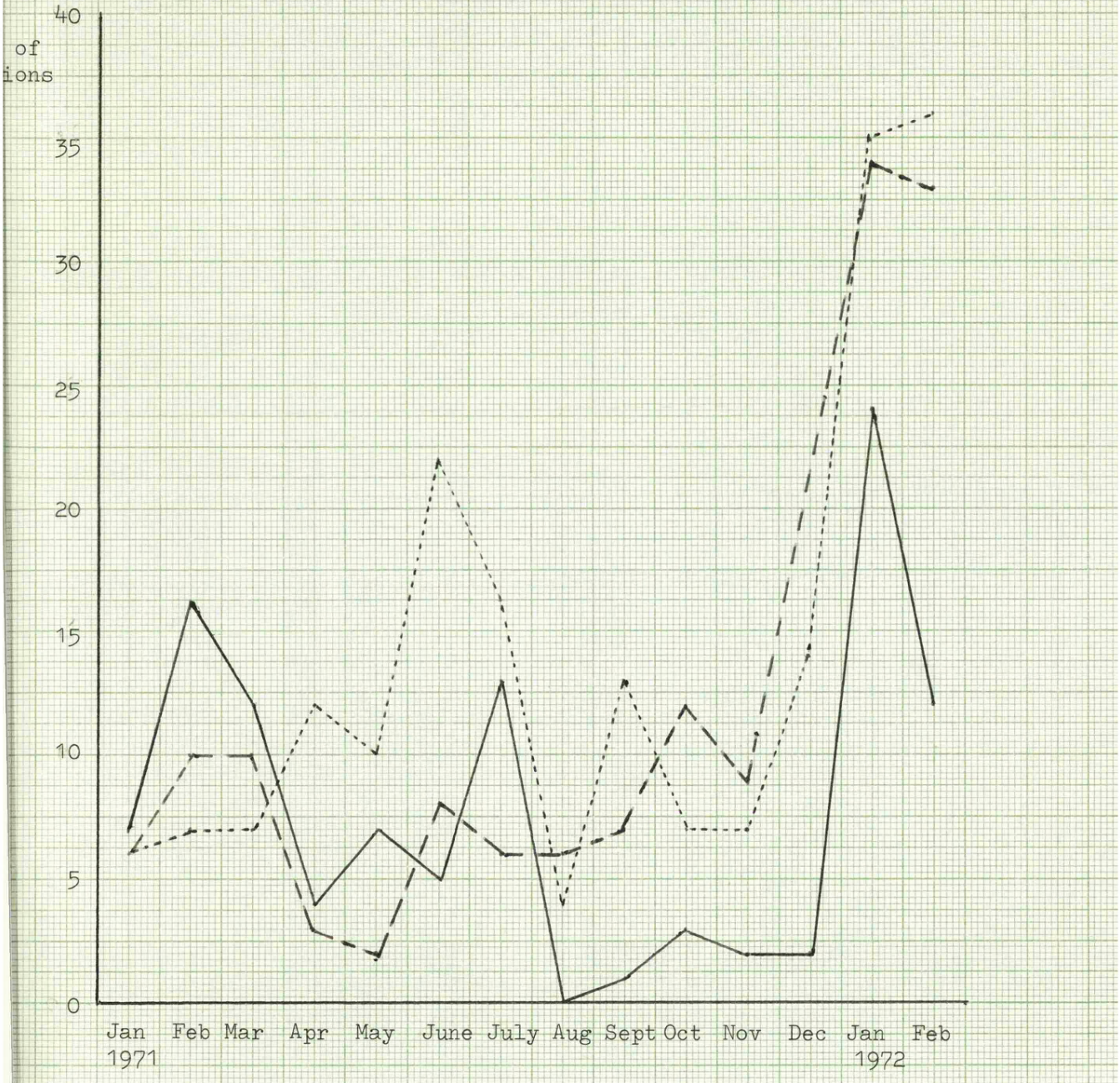
Subject Heading	Coding Category	Incidence	
1. Interest in exchanges of visits with Wards	Extra Mural Matters	4	
2. Going to First Aid Classes/Doning Blood	" " "	4	16
3. Going to Folk-Singing Evenings	" " "	5	
4. Collection and Distribution of Tin Foil	" " "	3	
5. Lack of Communication in the Villa	Evaluative Concerns	6	
6. Reasons for non-attendance at meetings	" "	2	10
7. Dislike of strangers in the Villa	" "	2	
8. Party arrangements	Administrative Issues	2	7
9. General Ward administrative problems	" "	2	

It is evident from this extract that the meeting during February 1971 were, for the majority of the time taken up with discussion of extra-mural matters; that is, with subjects concerning things outside or away from the Villa. In isolation, figures such as these mean very little, but, when they are seen in the perspective of a graph representing changes over a period of thirteen months certain trends become apparent:-

FIGURE 14

Graphical Representation of the Contents of the Thursday General Meeting

January 1971 - February 1972



KEY:

——————— Extra Mural Activities

- - - - - - - - - - - - - - - - - Administrative Issues

— — — — — — — — — — — Evaluative Concerns

SOURCE: Daily Ward Reports : Woodside Villa

(i) When discussion of extra mural matters increases noticeably (June - July 1971, December 1971 - January 1972), attendances at the Thursday meeting are at their lowest. (See Figure 9, P.300).

(ii) During periods of continuous disturbance in the Villa (November 1971 - April 1972 - See Figure 11) discussion of 'evaluative' concerns at the Thursday meeting increases to match that of administrative issues, despite the fact that attendances at this meeting for much of the time are relatively low.

One explanation for these trends favoured by the ward Registrar was that in the case of (i), patients were experiencing uncertainty about the 'safety' of the Villa as a home and reacted to this by rejecting his request to use the Thursday meeting as a problem-solving as well as an administrative session. This psycho-analytically oriented interpretation, acknowledges W. R. Bions notion of 'fight-fight' in which it is suggested that since self-preservation is the primary function of any group, only two techniques of achieving this end are open to group members; 'fight' or 'flight'.[1]

Whether 'fight-flight' can explain the 'substitution effect' is debatable, but as an example of what is meant by this, it is worth noting that during the period mentioned in (i) above, attendances at the psychotherapy groups and at the Tuesday psychotherapy meetings were above average.

In other words, it appeared that patients sometimed preferred the security of the psychotherapy groups and meetings during periods when the atmosphere in the Villa was strained, and would use the Thursday meeting at such times, as a means of expressing uncertainty either by (a) failing to attend in large numbers, or by (b) discussing extraneous, often super-

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[1] Bion W. R. Experiences in Groups and Other Papers. Tavistock 1961. pp.59-75.

fluous issues.

When these situations occurred it was generally the case that the problems facing the community were resolved at an individual level through participation at the small groups. 'Flight' in circumstances such as these was, therefore, containable and was unlikely to be manifested in further disturbance or social fragmentation. On the other hand, in the case of (ii), 'fight' rather than 'flight' seemed the probable reason behind increasing use of Thursday meeting time for the discussion of 'evaluative' matters during the period referred to. The extent of the threat to the security of the community, consequent upon the Registrar's departure, was considerable and required that everyone pull together in order to prevent any further dislocation to the social structure of the Villa. Despite continuing disturbance on the ward throughout the entire period in which staff changes occurred, the patient community utilised the Thursday meeting for both administrative decision making and for the resolution of emotional and other problems.

Although the Registrar had failed during his two years in residence to increase the number of general meetings, he nevertheless achieved a measure of success in encouraging the discussion of social and emotional issues at what was considered to be an 'administrative' meeting. It was his belief that social interaction through open discussion in an organised group setting under the management of elected patient representatives, complemented and reinforced the experience of group psychotherapy.

It is difficult to estimate from the graphs how far non-attendance at key meetings such as the Thursday meeting reflected underlying faults in the community's meeting structure. 'Substitution' clearly took place when one type of meeting failed to provide the necessary kind of support for individuals or groups of patients, however, when two tests of significance

were carried out on (i) comparative attendance figures for all patients at the three kinds of meetings, and (ii) comparative attendance figures for male and female patients at all meetings, it was found in both cases that there were no significant differences in attendance patterns, which, contrary to expectation, suggests an underlying degree of consistency not evident from observation of ward behaviour.[1]

In conclusion, it must be stressed that graphical measures such as those discussed during the course of this chapter, do not always provide accurate indications of behavioural trends and yet without them, random observations often only give rise to further guesswork and hypothetical reasoning. Their value lies in illustrating 'trends' from which more specific hypotheses and methods of testing develop. It was as a result of these findings that a decision to use special questionnaires was made, for it had become fairly obvious to the researcher that a comparison of observed with reported data would help to show whether initial observations were correct or mistaken.

In the next section some of the ways in which questionnaires and rating scales were used, will be discussed in reference to the continuing development of the research strategy.

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[1] For supportive data and calculations see Appendix to Chapter 13, pp 397-419

2. Reported Data : Rating Scales and Questionnaires

Participant observation at Woodside Villa during the first three months of research resulted in a dearth of experimental ideas and a great deal of insubstantial material. What appeared to derive from observational data were certain assumptions about the relationship between organised activity and general ward behaviour, namely that:

(i) inconsistent patterns of attendance at meetings could be related to key events in the general life of the community, e.g. the arrivals and departures of key members of staff.

(ii) the level of anxiety or depression could be similarly related to significant events taking place on the ward (although no clear relationships could be established due to the incompatability of the various graphs).

(iii) the ability of the community to deal with disruptive behaviour seems to have been weakened by inconsistencies in staff leadership despite the fact that attendances at meetings remained consistent throughout the year.

(iv) female patients had a tendency to express anxiety in a more overtly aggressive manner than their male counterparts, and there is a strong possibility that women were unconsciously 'acting out' for the men.

(v) it was possible that patients experiencing psychotic disturbance reacted differently to psychotherapy and to changing events in the Villa from those patients with neurotic or personality disorders. Although unconfirmed, it was suspected by some members of staff that patients manifesting psychotic symptoms tended to withdraw from the rest of the community particularly during meetings when the level of anxiety in the Villa was high.

The question uppermost in the researcher's mind was whether or not these trends reflected inconsistencies in the therapeutic policy of the Villa. How was one to know, for example, whether the level of disturbance was abnormally high at any given time? Similarly, was non-attendance at meetings a normal or pathological feature of this 'therapeutic community'? A further issue that was discussed from time to time, was whether 'schizophrenic' disorders responded well to psychotherapeutic treatment, particularly in light of the fact that within the 'tradition' of the therapeutic community 'psychoneurotic' and 'personality disorders' have tended to be viewed as 'most responsive' to these treatment methods.

In order to try to answer some of these questions a series of new tests were carried out in which both staff and patients were asked to participate. They consisted of the following:-

1. A Rating Scale of patients' behaviour designed to enable staff to make an assessment of patients' 'levels of adjustment' over the period of time that they are undergoing treatment in group psychotherapy.
2. A Direction of Interests Questionnaire (DIQ) and Treatment Expectancies Questionnaire (TEQ) both of which were designed to assess a patient's <u>suitability for psychotherapeutic</u> (as distinct from physical or behavioural) <u>treatments</u>.

1. <u>Rating of Patients' Behaviour</u>[1]

This rating scale, containing 17 behavioural categories, each of which is designed to measure a patient's 'degree of adjustment' was originally devised for use at Claybury Hospital. An assessment of a patient's behaviour would be carried out with the use of this Rating Scale at an early stage in his or her involvement in a psychotherapeutic

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[1] Caine T.M. Principle Psychologist, Claybury Hospital, Chingford Essex. For complete questionnaire, see Appendix to Chapter 13, pp. 400-402.

group situation. Further assessments would then be made during, or at the end of a course in treatment and patient improvement would be measured according to the increase in the score which would represent further adjustment towards the theoretical 'normal'. The components rated on this scale were as follows:-

Attitude to the group as a whole.

Attitude to other individual members of the group.

General behaviour.

Suspiciousness.

Egocentricity.

Rigidity.

Dogmatism.

Dependence.

Willingness to reveal self.

Verbal participation.

Taking in what is said.

Insight at an intellectual level.

Insight at an emotional level.

Empathy.

Ability to accept criticism.

Ability to offer criticism.

Motivation to change.

Unlike Caine's use of this Scale as a continuous measure of improvement in psychotherapy, its employment at Woodside Villa was designed to assess instead:-

(i) the extent of agreement or disagreement between ward staff and group psychotherapists about the behavioural adjustment of patients at one point in time. The aim of this comparison was to establish whether behavioural adjustment was interpreted differently by ward staff whose experience of patients covered the full 24 period, from that of therapists whose experience of patients in psychotherapy alone, covered only $4\frac{1}{2}$ hours of any week. It was hypothesized that significant differences in scoring would reflect discrepancies in communication between ward staff and therapists and that such a situation could be interpreted as being dysfunctional to the community.

When Spearman's rank correlation coefficient was applied to the comparative scores of staff and therapists it was found that at the .05 level of significance the two scores were not significantly different, allowing for the interpretation that staff evaluations of behavioural adjustment of patients in the general social setting of the ward were in accord with therapists assessments of adjustment in the course of group psychotherapy. This finding suggests that psychotherapeutic and general nursing approaches in the community complemented rather than opposed each other.[1]

(ii) the extent of agreement or disagreement between ward staff.

Since each member of staff completed a Rating Scale for each patient, comparisons of scores promised to show how far one staff member's scoring of a patient's behaviour accorded with that scored by close professional colleagues. The researcher's general contact with members of staff led him to believe that differences of opinion were only slight and that as a team, considerable consistency would be evidenced by the score results.

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[1] See Appendix to Chapter 13, P. 403.

As it turned out, Spearmans rank correlation coefficient showed that:-

(a) the two charge nurses scores differed significantly, whereas,

(b) there were no siginificant differences in the scoring between the two charge nurses and the (one available) nursing sister.

These findings are of interest because they substantiate the view that when disagreements did take place between staff they tended to reflect the somewhat different attitudes towards treatment held by the two charge nurses.[1]

Having established that consistency of opinion over the rating of patients behaviour was evident in the comparative scores of the therapist and staff groups, it is interesting to learn that when the finished rating scales were separated by 'diagnostic group' it was found that the combined staff-therapist group scored 'psychotic' patients lower on the adjustment scale than 'non-psychotic' patients.

This observation raised a number of important questions for the researcher, particularly in view of the fact that 'diagnosis' tended to be de-emphasised in discussions of patient selection and improvement in psychotherapy. Was it the case, for example, that patients manifesting 'schizophrenic' as distinct from 'hysterical' or 'obsessional neurotic' symptoms were thought to require longer periods of adjustment? or that 'psychotic' patients were thought to respond less well to psychotherapeutic treatment?

A comparison of scores on the rating scales showed that 'non-psychotic' patients were given a mean adjustment score of 56.42 as compared with 50.28 for 'psychotic' patients. In order to find out whether a difference really did exist in the scoring of the two groups, it was decided that a Chi-Square (X^2) test of significance should be carried out on the data

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[1] For data relating to these rating scales see Appendix to Chapter 13 pp. 404-405.

to determine whether variations were due to random variables or were indicative of differences in attitudes towards the treatment of psychotic and non-psychotic disorders.

The results of the test show that at the .01 or 1% level of significance the calculated value of 0.21 does not reach the tabulated value of Chi, and for this reason the null hypothesis which states that differences in the scoring of 'psychotic' and 'non-psychotic' patients is due only to random variables, is accepted.[1]

Having found that no significant differences existed between the scoring on the adjustment scales the researcher was able to conclude that consistency of opinion over treatment policy was in greater evidence than was at first thought which provides further support for the therapeutic viability of treating mixed diagnostic groups in a 'therapeutic community' setting.

So far the information drawn from the Rating Scales refers to overall levels of adjustment taken from the total scores given by staff for each patient. Unfortunately, such scores tell us nothing about the individual components on the scale and how patients are seen to have 'adjusted' in terms of these.

Although it was established that no significant differences had been observed between the general scores of 'psychotic' and 'non-psychotic' patients, it was decided that a further comparison would be made of the component scores for each 'diagnostic' group in the hope of finding out whether adjustment on individual component scores was thought to differ according to 'diagnosis'. Once again Spearman's rank correlation co-efficient was applied to the data with the result that no significant differences were found to exist between the component scores for each diagnostic group.[2]

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1 & 2 See Appendix to Chapter 13, Section No. 8, pp 406-409.

What was noticeable however, was that in the case of four components the 'psychotic' as distinct from the 'non-psychotic' patients were thought to be:-

(i) less able to offer criticism

(ii) more suspicious

(iii) less able to participate in verbal exchanges in groups, and

(iv) more dependent upon the group.

On most of the other components staff and therapists rated both diagnostic groups as similar in degree of adjustment.

What is perhaps significant about the four components singled out as being 'noticeably different' is that they tend to conform to general expectations about the reduced ability of patients experiencing psychotic disturbance to function successfully in psychotherapeutic group situations. This observation suggests that diagnostic differences were recognised in evaluations of patient improvement even if they were not stressed during the process of patient selection.

Caine's Rating Scales enabled the researcher to assess staff and therapists views concerning variable 'adjustment' of patients all of whom were undergoing treatment in group psychotherapy. The findings of these scales suggested that:

(i) there was agreement between ward staff and therapists over assessments of patients' behavioural adjustment on the ward. Since ward staff had contact with patients to a greater extent than did the therapists, agreement of this kind implies that the behaviour of patients both in groups and on the ward was thought to be inconsistent. For this reason it seems reasonable to suggest that the 'milieu' of the Villa was supportive to the psychotherapeutic process despite the fact that observations of daily events tended to suggest the contrary.

(ii) a mixed diagnostic patient population can respond with equal success to treatment in a psychotherapeutic group situation even though patients manifesting symptoms of 'psychotic' disturbance may be less able to participate verbally or may be more suspicious about the aims of treatment.

2. Questionnaires

The rating scales referred to in the previous section were limited to the extent that they only provided a measure of staff opinion about the behaviour of patients in the Villa. Up until the latter stages of the project, no attempt had been made to involve the patients themselves in any of the tests, due partly to the difficulties encountered in achieving a representative sample of respondants. Some patients expressed feelings of mistrust towards the aims of research, sometimes referring to themselves as 'guinea pigs' whereas others felt unable to participate due to their confused states of mind or dislike for 'questioning'.

After the findings of the rating scales had been made known to the ward registrar and the nursing staff, it was suggested that the researcher should try to ascertain whether any further evidence could be found to support the view that a mixed diagnostic patient population can respond with equal success to involvement in a psychotherapeutic group process. It was felt that confirmation of this fact would in some way provide a strong argument in favour of the continuation of Woodside Villa as a 'psychotherapeutic community'.

(a) Treatment Expectancies Questionnaire (TEQ)[1]

This questionnaire was selected for use in the Villa because of its simple format. It had been designed by T. M. Caine as a means of guaging patients' suitability for psychotherapeutic as distinct from physical therapies. The TEQ consists of a series of 28 statements

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[1] For an assessment of the Complete Questionnaire see Appendix to Chapter 13 Section No.10, pp 410-413.

followed by a choice of four possible replies, all of which are assessed on a True-False continuum. For example:

Statement	Reply
Treatment does not solve your problems, but makes you feel able to cope with them:	T PT PF F

The replies, consisting simply of ticks against the appropriate letters, represent the answers: (i) True (ii) Partly Ture (iii) Partly False (iv) False. The manner in which replies are scored is as follows:-

False = 1 Partly False = 2 Partly True = 3 True = 4

Not all the statements were designed to be scored. In fact, out of the original 28, only 15 were selected for final analysis. Furthermore, the scoring technique did not rely upon absolute scores, but was based instead upon a pre-determined average. In this way it was hoped to avoid the problem of patients trying to guess the 'right' answers.

Caine's samples consisted of outpatients all of whom had been diagnosed as suffering from 'psychoneurotic' or 'behavioural disorders' either during the course of, or after having terminated psychotherapeutic treatment in groups. Scores for both sample groups in response to the TEQ were as follows:-

Patients having dropped out of psychotherapy groups

N = 52 Mean Score 35.73 Standard deviation 6.86

These patients were thought to be unsuited to psychotherapeutic treatment in groups and better suited to physical or behavioural therapies.

Patients having undergone and still continuing involvement in psychotherapeutic groups.

N = 34 Mean Score 32.29 Standard deviation 4.74

A mean score of 32.29 was said to characterise the treatment preferences of patients who were suited to this mode of treatment.

The above mean scores were taken as sources of comparisons for scores deriving from questionnaires administered to patients at Woodside Villa. The Woodside sample differed from Caine's sample in the following ways:-

(i) Sample size was considerably smaller e.g. N = 20 as compared with 86.

(ii) The sample included patients experiencing 'psychotic' as well as 'psychoneurotic' forms of disturbance.

(iii) Patients at Woodside Villa had all been actively involved in group psychotherapy for periods of up to 20 months.

1. The mean score for the total group of patients at Woodside Villa was 31.85, which is lower than the score calculated by T. M. Caine for patients who had been in psychotherapy for a reasonable length of time without dropping out, and were for this reason deemed to be suitable candidates for group psychotherapy.

Given that the range of disorders ascribed to patients at Woodside Villa included both psychoneurotic and psychotic conditions it would appear from the score results that after a period of time in group psychotherapy, all patients, regardless of diagnosis could be said to have become 'suited' to this mode of treatment.

2. On separation of the scores for diagnostic groups it was found that the mean score for patients in the 'psychoneurotic and behaviour disorder group' was 30.0 (N = 12) when that for the 'psychotic' disorder was 34.6 (N = 8).

It could be argued that the overall suitability of Woodside patients to psychotherapeutic treatment methods may have been due to the supportive nature of the ward milieu. Naturally, one can only speculate over this issue, however, when it is taken into consideration that Caine's sample of

outpatients did not have the benefit of building relationships with other group members outside of the therapy hours, it is perhaps not so surprising that a larger proportion of them actually dropped out of therapy. Living within a community enables group members to assess the value of psychotherapeutic involvement both within and outside group time, and for this reason their expectations concerning treatment methods are more likely to reflect an optimistic, interpretive and communalistic attitude, than an individualistic more pragmatic attitude that could be said to characterise the attitudes of patients undergoing behavioural or physical treatments.

Conclusions

The TEQ assesses a patient's suitability for psychotherapy by suggesting that reacting to a body of propositions about treatment can reveal expectations believed to be in accord with the evaluative, self-directing nature of the group psychotherapeutic process. It was found that patients at Woodside Villa were en bloc suited to this mode of treatment regardless of diagnostic variations, which suggests that ongoing treatment in a supportive milieu decreases the likelihood of 'dropout', and increases the likelihood of longer-term success.

(b) Direction of Interests Questionnaire (DIQ)[1]

Like the TEQ, the Direction of Interests Questionnaire seeks to assess the suitability of patients for psychotherapeutic treatment. In this case, however, Caine assesses responses according to the extent to which they show that a patient is 'inner' or 'outer-directed'. It is suggested that the more 'inner-directed' the patient is, the greater is the likelihood that he or she will be suited to psychotherapeutic treatments.

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[1] For copy of questionnaire see Appendix to Chapter 13, 11, pp. 414-417.

The DIQ consists of 15 pairs of propositions to which the patient responds by choosing from each pair the item that is considered to be 'true' or 'more true' than its counterpart. It is explained in the instructions to the questionnaire that there are no 'right' or 'wrong' answers, therefore, it is simply a question of giving a preference as spontaneously as possible.

The completed questionnaire is scored in the following manner. As in the case of the TEQ, a score card is used to ascertain which of the responses reflect characteristics of 'inner' or 'outer directed' thinking - based upon recognised methods of psychological testing.[1] The specially perforated card is placed over the answer sheet and when a tick corresponds to a hole on the card a score of 2 is given. Conversely, when a blank corresponds to the hole, a score of 1 is given.

Caine's analysis of his respondents' returns, revealed a mean score of 14. He concluded that patients who scored over 14 were more 'inner directed' than those who scored below this figure, and, therefore, the former were better suited to psychotherapeutic treatment in groups than the latter.

Twenty of the patients at Woodside Villa agreed to respond to the Direction of Interests Questionnaire. The results were as follows:

(i) A mean score of 16.1 was calculated from the returns for all patients which exceeds the figure that is required if one is to conclude that Woodside patients were en bloc 'inner directed' and, therefore, suited to group psychotherapeutic treatment.

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[1] For fuller explanations of these methods see bibliography, under Caine T.M. & Smail D. J.

(ii) Separation of scores by diagnostic group (those patients described as manifesting 'psychotic' as distinct from 'psychoneurotic' symptoms) revealed only minor differences in mean score values. Patients of the 'personality and behaviour disorder' type were found to have a mean score of 16.5 compared to 15.5 for the 'psychotic' group. As a means of discovering whether these scores were significantly different it was decided that a significance test would be applied to the data.

Using the Mann Whitney 'U' test for comparisons of independent samples drawn from the same population,[1] it was found that the rank scores for both diagnostic groups were not significantly different. Furthermore, when the same test was applied to score data deriving from the Treatment Expectancies Questionnaire, it was once again found that there were no significant differences between the scores of either group.[2]

Summary and Conclusions

During the course of chapters 12 and 13 discussion focussed upon some of the ways in which observed and reported data have been used to elucidate some of the more important aspects of Woodside Villa's development as a 'psychotherapeutic community'.

At the request of the ward registrar the researcher became involved in all aspects of life in the Villa, and as a result was able to provide information concerning the relationship between the psychotherapeutic treatment process and social interaction processes on the ward.

Participant observation during the first two months of the project resulted in the development of a series of graphical measures and scales through which the relative significance of behavioural events were assessed.

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1 & 2 See Appendix to Chapter 13, 12 & 13 pp.418-9.

An analysis of (i) attendance figures for key meetings suggested that a 'substitution effect' was in operation, emanating from uncertainty amongst patients about the ability of each type of meeting to deal with problems of anxiety. Further analysis of (ii) the contents of nursing staff's ward reports appeared to suggest that periods of disturbance or depression followed a cyclical-type of pattern.

A combination of (iii) diary notes and graphical measures based upon an evaluation of the contents of the ward reports, revealed that periods of extreme agitation, particularly amongst female patients, coincided with the unannounced arrivals and departures of key members of staff. It was also observed that attendances at psychotherapeutic groups would tend to fall when these groups failed to help patients to deal effectively with stress or anxiety. Two tentative conclusions were drawn from these findings:-

1. Inconsistencies in staffing policy, due largely to the lack of communication between the central nursing administration and Villa staff, may have contributed to the maintenance of anxiety and disturbed behaviour on the ward;

2. During times of maximum disturbance it was not possible to say that the 'social milieu' of the ward was 'supportive', because the meeting structure showed signs of failing to cope with increasing anxiety.

In an earlier chapter it was suggested that the success of a 'therapeutic community' depends in part upon the maintenance of a reciprocal interrelationship between the 'psychotherapy' enterprise and the 'sociotherapy' enterprise; that is, where a similar emphasis is placed upon the need for the improvement of 'social skills' as for 'intrapsychic integration'. Although it makes little sense to speak of an 'equal balance' between these two processes, it is nevertheless valid to

point out examples of obvious disparity, such as was evident for periods of time at Woodside Villa.

Since it was accepted by the ward registrar that communal living was an integral part of treatment, social dislocation on the ward was recognised as a hindrance to patient progress. For this reason, attempts to establish the sources of dislocation were seen as being of importance to the future of the community.

The discovery that disturbance on the ward reflected a pattern of inconsistencies in staffing changes in staff were made by the central administration who, in most cases, acted independently of the ward staff body. This meant that with insufficient managerial autonomy to determine its own staffing policy, Woodside Villa had the resources available to pinpoint internal problems but was virtually powerless to deal with them.

This situation, reminiscent of what Muzekari has described as the problem facing an "autonomous, encapsulated organisational structure" in which the goals of the community and that of the larger organisation are often incongruent,[1] was what stood between success and failure for Woodside Villa. Without clear evidence that a communal living situation complemented and supported the psychotherapy enterprise, it was only a matter of time before the critics would have found a way of putting a stop to the experiment. It was, after all, possible to engage in group psychotherapy without having the added comforts of private rooms and communal living arrangements, not to mention the benefits of patient participation in decision-making on the ward. Atkin's observations of the kinds of resentment felt by other hospital personnel towards patients and staff who were thought to be leading 'privelaged' lives at Woodside Villa, illustrates the difficult background against which the community

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[1] Muzekari L.H. The Therapeutic Community and the Mental Institution: A New Perspective. Psychological Reports 1970, 26, 1.

was forced to develop.

Significantly, shortly after the Registrar's departure from the Villa, rumours started circulating about the intention of the hospital administration to move all of Woodside's residents to another Villa in which there would not be provision for private sleeping accommodation. The rumours were soon to be proved to have a basis in fact for within a few months the proposed event was given formal sanction. The researcher was informed that the official reason given for the transfer was that pressure to provide more accommodation for nursing staff precluded the further use of Woodside Villa as a patient-residence.

Whether the dissolution of Woodside Villa as a special community represented a genuine need to reallocate resources, is a question to which no adequate answer can be found. Clearly, dissatisfaction was experienced by some senior hospital personnel concerning the general manner in which the ward was being run, but one can only speculate as to the influence that this had upon the decision to move the patients to a more conventional building.

Observations made during the course of the researcher's involvement in the Villa would tend to support the view that external pressures played a significant role in undermining the community's ability to remain self-supporting.

With insufficient organisational autonomy, Woodside Villa always faced the prospect of outside intervention and for this reason found itself unable to provide a firm enough base upon which to establish workable principles of therapeutic community treatment organisation.

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PART 4 - CONCLUSIONS

CHAPTER 14 BEYOND THE THERAPEUTIC COMMUNITY?

SUMMARY

Although the main objective of this book has been to elucidate the concept of the therapeutic community as a psychiatric process, it is important to remember that the theoretical orientation of the study is sociological and not medical. The point of making such a distinction is that, too often, it has been assumed that interdisciplinary contributions to this field are complementary when in many cases they are not.

In Part 1 it was stressed that notions of 'medical' and 'social' models of mental disorder are insufficiently clear to enable an understanding of the complementarity between the social sciences and medicine. These issues were further borne out in Chapter 6 where it was argued that much of the confusion surrounding the concept of the therapeutic community derives from ambiguous theoretical premises.

In Chapters 1 and 2 we saw how dualism in sociology and psychiatry reflects the problem of validation in the social and behavioural sciences. A number of writers have referred to dichotemous modes of explanation and to 'crisis' in the theoretical development of both disciplines. Unfortunately, the theoretical divisions inherent in both disciplines are magnified when sociologists attempt to define their roles in the psychiatric setting. Chapter 3 attempts to explain how the role of the sociologist in psychiatry will vary according to the differential emphasis placed upon involvement in the treatment process

or work on behalf of psychiatric medicine. The question facing the social scientist is whether he should see himself, as a social epidemiologist, identifying trends and correlates of behaviour, or as 'situational actor', not only involved in the context of his subject matter, but part-creator of the environment he pledges himself to study. These issues will be referred to again later in this chapter.

In Part 2 the origins of the concept of the 'therapeutic community' were traced through a review of social medicine since 1790, with special emphasis being placed - in Chapters 5 and 6 - upon the development of milieu therapy and the reaction to custodialism throughout institutional psychiatry during the past thirty years.

In Chapter 5 it was argued that much of the ground work for change was laid after the second World War and five factors were quoted as being of especial significance; (i) 'advances' in psychopharmacological research, neurosurgery and the mechanical therapies (ii) the 'open door' policy in mental hospitals, (iii) the instigation and development of the occupational and work therapies, (iv) changes in the status of mental patients after 1959, and (v) the influence of critical studies of mental hospital practice by social scientists.

Chapter 6 provides a general overview of the literature pertaining to the 'therapeutic community' and milieu therapy, and argues that much of what has been taken for granted about types of social structure, modes of therapy, and goals of treatment, in fact requires more thorough investigation. Instead of there being a consensus of views about central issues, considerable uncertainty and confusion exists. The literature shows that there are two main types of approach to the therapeutic community concept - descriptions of units in operation which seek to <u>define</u> the basic constituents of therapeutic communities, and

those accounts of differently constituted milieux, which refer to themselves as 'therapeutic communities' by a process of qualification.

Part 3, contains the results of the author's own field research which was carried out in two stages over the period 1971-2. Stage 1 (Chapters 7 and 8) which was concerned with staffs' definitions of therapeutic community, shows that a fairly stereotyped image of social structure and goals exists, and Stage 2, which describes a participant - observational study of a developing therapeutic community, provides insight into the difficulties of evaluating the ever-changing 'atmosphere' of a community in transition. Chapters 9 - 13 explore the world of a psychiatric hospital villa and its struggle to survive within the larger institution, as well as the problems encountered by the author in attempting to compromise two different approaches - the search for an acceptable (i.e. empirically justifiable) research strategy and the need for full-time personal involvement in the daily life of the unit.

CONCLUSIONS

It is the author's contention that the concept of the therapeutic community is seen to be 'progressive', because it is ideologically opposed to 'traditional' psychiatry. Whereas custodial organisation and the physical and mechanical therapies are thought to represent 'untherapeutic' psychiatry, 'milieu therapy' and 'therapeutic community' methods are equated with the modern 'therapeutic' variety of approaches to the treatment of mental disorders. It is an inescapable conclusion that in viewing old and new methods in this manner, notions of 'bad' and 'good' psychiatry emerge and hence 'progress' is seen to be linked with the rejection of the old regime.[1] Were it not for the fact that

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[1] For an example of this type of reasoning see reference to Clark and Yeomans 'Frazer House' in Chapter 6, note 2, P. 132.

objections can be raised about the necessity for a medical model of mental disorder and treatment, the equation of 'therapeutic community' with 'progressive' (i.e. good) psychiatry, would probably continue to be taken for granted. It would seem that the debate over which kinds of approach are the most therapeutically viable, does not go far enough. Since it is assumed that the care of the mentally disordered is a medical responsibility, it is only to be expected that the kinds of questions posed will reflect the traditions and the aspirations of medical science. But is it necessarily the case that change should be initiated by the medical fraternity?

The emphasis upon social and community care for the mentally disordered since the 1959 Mental Health Act, has moved the locus of interest away from the mental hospital to the wider social community. Many doctors respect the contribution that the social sciences have been able to make to medical knowledge and it is accepted that much of the direct intervention work that takes place between client and 'care officer' should be now located in day centres, social work agencies or other non-institutional places of refuge. The relevance of organic theories of psychopathology to the understanding of mental disorder has been modified to incorporate theories of social and environmental maladaptation.

There are signs, however, that some psychiatrists are beginning to react unfavourably to intrusions from other disciplines, notably the social sciences. In a number of cases this takes the form of attempts to subsume 'social models' of pathology and other such theories linking environment with mental disorder - under a more general medical model.[1,2,3]

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[1] Mitchell R. Medical Model vs Social Model. Nursing Times, Nov.28th 1974 pp.1851-1853.

[2] Mitchell R. The Therapeutic Community vs Traditional Psychiatry. Nursing Times, Nov. 21st, 1974 pp.1810-1812.

[3] Kaufman M.R. Psychiatry : Why Medical or Social Model? Archives of General P ychiatry, Vol.17, No.3, Sept.1967.

"The traditional form of psychiatry is rooted in the well tried and well respected medical model : the therapeutic community is rooted in the less well tried, but no less potentially respectable sociological model. Each has its place, its values and its aims, rules and effects. Neither can nor should claim to contain within it the answer to all problems and all human dilemmas".... however ..... "It is suggested that a rigid hierarchical medical model can be humanised by being imbued with therapeutic community principles. Sociology can penetrate into medicine and can cast light upon it".[1] Social scientists are clearly being shown 'their place'. The implication is obvious; treatment and care are the responsibility of medically trained personnel, whereas advice about how to improve these services can be usefully provided by social scientists.

In a recent paper addressed to the Personal Social Services Council, Professor F. M. Martin spoke about an 'uncritical acceptance' by most social services agencies of a "conception of mental illness which is excessively influenced by analogies drawn from the field of physical disorder. As a result"... he continues..... " the relationship between the medical and social components of care has generally been interpreted unimaginatively, with the social needs of the psychiatric patient in the community being seen as largely parallel to those of the patient with a chronic physical illness or disability."

Furthermore, he is of the opinion that "knowledge derived from sociology and social psychology concerning relationships between staff practices and attitudes on the one hand and patients' progress on the other has had less influence than might have been hoped on the detailed planning of psychiatric facilities and their management"..... mainly because....."under the general heading of mental illness we have indiscriminately brought together a number of conditions of undeniably

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1 Mitchell R. Op Cit Nov. 21st 1974, P.1812 (my italics).

2 These issues were discussed in some detail in Chapter 6.

organic origin (however much they may be environmentally modified or however far reaching their social consequences) and a number of others for which 'illness' is only a metaphorical title and possibly a misleading one, in that they are essentially 'problems of adjustment' or 'problems of living'." The effect of bringing the latter under the control of psychiatric and general medical services is that "we may inadvertently both encourage methods of treatment which can never be more than symptomatic and divert attention from the need to search for root causes in human experience and its social context. We may also do less than justice to the therapeutic potential of the non-medical professions".[1]

An issue of considerable significance emerges from discussion of these sources. It concerns the reasons for role ambiguity experienced by social scientists working the medical field which, it is suggested, derives from underlying discontinuities in the theory and methodology of the social and behavioural sciences.

Let us consider two examples of the kinds of problems facing the social scientist in his work within the psychiatric setting.

In the first case, if the sociologist is to accept the role of 'social consultant' or 'advisor' he has to come to terms with the fact the he is tacitly reinforcing the 'medical model' of diagnosis and treatment by relinquishing any right to take responsibility for the process of therapy.

Regardless of his opinion about the efficacy of the 'medical model', he is obliged to accept that only doctors have the statutory right under the Mental Health Acts to decide upon a patient's treatment and rehabilitation.

In the second case, there is the problem faced by the sociologist working as one of a 'team of therapists', in a 'therapeutic community'.

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[1] Martin F.M. Better Services for the Mentally Ill : a discussion note. Presented to the Personal Social Services Council, December 1975. (my italics).

By virtue of his role in group psychotherapy and the community decision-making process, he sees himself as having a 'therapeutic' (i.e. treatment) function as well as a research and information-providing function. Due to his awareness of the restrictions placed upon him by the sociological community (the problem of 'normative involvement' affecting the reliability of data) and by the medical profession (absence of formal training) he is forced to consider where the boundaries of his responsibility actually lie. In view of the considerable changes that are taking place in the general field of mental health, particularly in the 'encounter' and 'family' therapies[1] it is not difficult to understand how the social scientist can find himself experiencing role ambiguity.

To add to these difficulties, the social scientist knows that doctors, whether they care to use the term or not, are committed to the task of treating 'illness'. In psychiatry, even when disorders are not referred to as 'illness', they are nevertheless treated as if they were illness because the institutional arrangements accompanying all levels of intervention are geared to notions of illness 'prevention' and the maintenance of 'mental health'.

Unfortunately, doctors, like sociologists, are easily misunderstood when they attempt to explain ways of combining interdisciplinary skills. Sociologists are attacked for underestimating the real value of medical expertise in alleviating suffering and doctors are attacked across a broad front for not giving proper consideration to the fact that much of what is described as 'mental illness' has little, if anything, to do with the bodily organism or the administration of physical or mechanical therapies.

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[1] For some interesting insights into the changing roles of social workers and family therapists, see 'Zen Social Work' by David Brandon, Social Work Today, vol.5, No.21 23/1/75 pp.638-641 and 'Therapy with Low Socio-Economic Families, by Brian Cade; Social Work Today, Vol.6 No.5 29/5/75 pp.142-145.

In defence of psychiatry, Anthony Ryle argues that many sociologists make a 'glib' assessment of the merits and demerits of medical intervention. 'Labelling theorists' in particular are criticised for missing the essential point in the medical treatment of mental disorders - that "patients have frightening and distressing experiences which lead them to seek psychiatric help".[1] He claims that one cannot honestly discuss the 'sick role' without noting the extent to which it confers help and protection.

However, without an alternative strategy for the care of the mentally disordered that has both legal sanction and social acceptance, it is hard to think of any other form of help that the frightened, distressed person can in fact receive. Ryle states that psychiatrists look after people suffering from difficulties derived from four main factors: 1) inheritance, 2) organic brain disease, 3)"ill understood, but apparently, in part at least, physiologically-determined disturbances of brain functions affecting moods and thinking", and 4) adverse life-experience leading to restrictive and self-defeating ways of living.

All of these are said to lie within the scope of a psychiatrist's treatment role, because, "As we move from groups (1) and (2) through (3) and (4) the relevance of physiological and medical concepts diminishes and that of psychological and social concepts increases".... therefore ..... 'Individual psychiatrists are likely to base their practice predominantly on the part of the spectrum using one of the underlying intellectual disciplines and conceptual frameworks. But few will do so exclusively and most, to some degree, consciously utilise the whole range of concepts in their understanding of their patients".[2]

It is debatable whether (3) and (4) are the sole province of the

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1 Ryle A. Glib Attacks on Psychiatry. New Psychiatry. September 19th 1974 P.20.

2 Ibid P.20.

psychiatrist, since a range of persons including priests and voluntary workers are capable of effecting change in the disordered person's mental condition. Whether medical training is necessary, or even appropriate in cases such as these, does not change the fact that only doctors have the legal right to deal with them.

To quote Ryle again:

"The problem arising from the dual role of the psychiatrist as healer and as agent of society, are not simple ones, but at least it must be made clear that when a psychiatrist exercises his powers under the Mental Health Act to compulsorily detain or treat patients, his action is based upon legally conferred powers and responsibilities. It does not represent in any way an illegitimate extension of the medical model".[1]

If a doctor's actions are judged to be legitimate by virtue of his legal status, it makes no sense to talk about 'illegitimate extensions of the medical model,' since no other group of persons have the authority to question medical decisions.

One of Ryle's objections to 'glib sociologists' is that "the crudity of their postures is likely to provoke an irritated closure of ranks and minds rather than open up discussion", yet he evidently fails to realise that it is precisely due to the exclusive manner in which sections of the medical profession choose to treat contributions by non-medical persons, that this 'irritated closure of ranks' takes place.

Returning to the problem of how the sociologist defines his role in the psychiatric setting, the position is not made any clearer by statements such as the following:

"Beyond the need to extend therapeutic resources, the transformation

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[1] Ibid P.20.

of everyday social life, which alone may one day diminish.... mental illness, is a task in which psychiatrists and sociologists can cooperate. Both have a professional role to play in identifying problems and both are capable of initiating change".[1]

What does 'cooperation' mean in this context? What is the nature of the 'professional role' that the sociologist has to play? What is meant by 'initiating change'? Ryle seems to be implying that social scientists can play a supportive role in matters of mental health, but it is not their business to judge the efficacy of the 'medical model', since this is the province of the psychiatrist.

The term 'medical model' has come to mean quite different things to different people. On the one hand it is used to denote dissatisfaction with classical 'disease' and 'illness' models, while on the other hand, it is seen to provide the rationale behind the application of medical knowledge to psychological phenomena. Shepherd, for example, has argued that:

"The words 'medical model' have degenerated into a jargon phrase which carries very imprecise meaning. As used by social workers they may refer to the organisation and structure of the medical profession; a style of therapeutic intervention, or a concept of dysfunction arising out of a disease entity".[2]

On a similar point, Brewer, a lecturer in psychiatry, asks why psychiatrists show a tendency to introduce 'medical notions into non-medical situations', and suggests that....

"By some accident of history, certain types of socially unacceptable behaviour and almost all types of individually unacceptable misery are

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1 Ibid P.21

2 Shepherd D. You and Research: Medicine, Madness and Methodology. Social Work Today, Vol.6, No.1 3/4/75 pp.17-18.

now regarded as the preserve of the medical profession, who naturally employ the methods and concepts of medicine". For this reason, "before a doctor prescribes drugs or recommends operation, he has to classify the patient as 'sick', since people who are not sick, don't need drugs; and conversely, people who are receiving drugs or ECT, must, by definition, be sick, unless the doctor has made a mistake".[1]

If some forms of 'socially unacceptable behaviour' are explained in terms of the 'pathology' of the social transaction, rather than the psychobiological organism, and if 'individually unacceptable misery' can be alleviated by contact with persons possessing therapeutic skills other than those associated with medical training, it would seem that the range of persons suitable for the role of 'therapists' extends beyond the conventional boundaries of medical psychiatry.

Psychiatrists interpret the role of medicine in the treatment of mental disorders differently, according to the emphasis that is placed upon its relationship to the physical sciences, Foudraine, for example, in common with Thomas Szasz, holds that although medical science can continue to be a branch of physical science, psychiatry cannot, because "it must become a scientific discipline, concerned with values, norms, rules, ethical issues - a 'moral science'."[2]

A 'demedicalization of psychiatry' would, he argues, give rise to a new kind of training for persons wishing to work with the mentally disordered. A new type of 'therapist' is envisaged.... "someone, who, having passed a preliminary qualifying examination (in psychology, medicine, sociology, pedagogics, social psychology, cultural anthropology)

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1 Brewer C. Last Years Model. New Psychiatry, 8/8/74 P.11

2 Foudraine J. Not Made of Wood. Quartet Books London 1974, P.388 (my italics).

undergoes a special course of study. First and foremost this would include the basic principles of sociology and psychology".[1]

Maxwell Jones argued along similar lines to this in 1968 in a discussion of future trends in psychiatry. He stated that a great deal more needs to be known about the processes of social learning before psychiatrists are able to make adequate judgements about the nature of mental disorders and further suggested that in the future:

"Psychiatrists may well tend to integrate more closely, not only with behavioural scientists, but also with educationalists".... because .... "much treatment in psychiatry could just as well be called social learning. For this trend to develop, there will have to be vast changes in the training and orientation of psychiatrists and a much greater sensitivity on their part to the feelings of the people whom they are attempting to help".[2]

For Jones, the psychiatric institution represents a microcosm of society and for this reason the same kinds of changes that can be initiated in the psychiatric setting by the application of 'therapeutic community' ideas and techniques, can be broadened to encompass the wider society.

But what does this mean in terms of the future development of 'psychiatric' as distinct from other forms of care methods? If 'psychiatry', which is a medical speciality, is broadened to the extent suggested by Jones, then it follows that what lies beyond the 'therapeutic community' must be a mode of 'social and community care' provided by interdisciplinary teams. The primary question that should now be asked is whether any one professional body is to be given the statutory right to determine care policy.

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1 Ibid P.390.

2 Jones M. Beyond the Therapeutic Community. Yale Univ. Press 1968 P.142

The acceptance of a medical model in the care and treatment of the mentally disordered reflects the dominant status of medicine in contemporary society. If we are to accept that the influence of the behavioural and social sciences upon attitudes to mental disorder will result in a concomitant de-emphasis upon the necessity for medical diagnoses and treatments, does this justify the expectation that future responsibility for the mentally disordered will be shared equally between non-medical and medical bodies? It would seem likely that before such partnerships emerge there will have to be considerable changes not only, as Jones suggests, in the training and orientation of psychiatrists, but also, as Margot Jeffreys has suggested, in the training and orientation of social scientists "to ensure that sociologists and others who are contributing to medical knowledge... are given the status and career prospects which they would have expected if they had stayed within... their parent discipline".[1]

Throughout this book it has been argued that 'dualistic' thinking has contributed towards confusion and antagonism between social and medical scientists. We have examined the differences between 'subjective' and 'objective' theories and methods in sociology and psychiatry, medical and social 'models' of mental disorder and 'custodialism' and 'milieu' therapy as indicators of 'traditional' vs 'progressive' approaches to treatment. If we are to see the development of interdisciplinary co-operation along the lines suggested by Jones and Jeffreys, public discussion of theoretical and methodological issues such as these will have to be encouraged and ways found to unify rather than separate training for work in the medical and paramedical fields. After all, if the success of any 'therapeutic community' or, for that matter, any social psychiatric milieu, derives from a recognition of the importance of teamwork, it would be fundamentally mistaken to let professional differences and prejudices delay the development of a unified approach to the care and treatment of mental disorders.

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[1] Jeffreys M. Op Cit 1969 p.115 (see also Chapter 3, p.65)

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APPENDICES

APPENDIX TO CHAPTER 7 PART 3

(a) Interview Schedule (Revised)

THE UNIVERSITY OF BATH

1971

The Concept of the Therapeutic Community

Stage 1 - Pilot Interviews

Aim* The aim of this interview is to assess the opinions of (a) medical (b) non-medical, and (c) nursing staff, concerning the utility of 'therapeutic community' and 'milieu therapy' techniques in the treatment of mental disorders. Respondants will be asked to answer questions relating to treatment in mental hospital and selected psychiatric settings.

Structure of Interview

Section	Subject Headings	Question Numbers
1	General Information	1-7
2	Previous Experience	8-9
3	Evaluation of Work Setting	10-11
4	Treatment Preferences	12-14
5	Criteria of Definition of Therapeutic Community	15-18b
6	Effectiveness of Therapeutic Community Methods	19, 21, 33, 43
7	Operative Treatment Processes	20 a,b,c
8	Patient and Staff Selection in a Therapeutic Community	22, 23, 25a,b, 39
9	Role and Task Satisfaction	26, 27, 34
10	Institutionalisation	28, 31, 32

The information collected during the course of this interview will be treated confidentially. The aim is to assess your opinion of therapeutic

* to be read out to the respondant

community treatment methods.

Section 1 General Information

1. Date of Interview
2. Place of Interview
3. Sex
4. Age
5. Professional Title/Status
6. Qualifications
7. Length of Service in present institution. How long have you been working in this hospital?

Section 2 Previous Experience

8. Have your previously worked in a psychiatric hospital/unit?
   If yes: Where?
9. How would you describe the type of treatment approach in use there?

Section 3 Evaluation of Work Setting

10. Is the unit in which you are presently working any (a) more progressive, (b) less progressive, than that in which you were previously working, or is it (c) much the same? (d) No former employment/other.
11. What methods of treatment are currently being used in this hospital?

Section 4 Treatment Preferences

12. Do you have a preference for any particular mode of treatment or treatment orientation?
14. Would you equate the use of therapeutic community methods in mental hospitals with 'progress' in psychiatric practice?

Section 5 Therapeutic Community: Criteria of Definition

15. What would you describe as the central features of therapeutic community treatment?

16. On what scale do you think a community can best function?

17. According to exponents of the therapeutic community, aims are generally agreed upon. However, the methods through which these aims are achieved vary considerably between hospitals. This has led to difficulty in assessing the positive contribution of therapeutic community methods to psychiatric practice. Would you agree or disagree with the proposition that this situation has arisen because:-

	Agree	Disagree
(a) Therapeutic community methods are poorly defined.		
(b) Mental disorders cannot be treated by these methods.		
(c) Formal medical and nursing training is inappropriate for work in a therapeutic community.		
(d) Milieu therapy methods have to be supplemented by other methods of treatment instead of relying upon the therapeutic potential of the 'total' environment.		
(f) Everybody's conception of what is therapeutic in the community differs.		
(g) None of these/other reasons.		

18b. Which (if any) of the features of your community do you think may be untherapeutic for the patients?

Section 6. Effectiveness of Therapeutic Community Methods

19. In your estimation, can therapeutic community methods be any more successful in rehabilitating patients than other treatment approaches?

21. It could be said that one of the main functions of therapeutic community treatment is to get the disordered individual back into the wider community as soon as possible with the minimum of distress. How realistic do you think this proposition is?

33. How would you define 'effectiveness' in terms of therapeutic community success?

43. Do you see 'community therapy' (both in and outside the hospital) as an answer to future problems of mental disorder?

Section 7. Operative Treatment Processes

20. (a) Democratisation Do you think that all members of the community can share equally in therapeutic and administrative decision making?

(b) Permissiveness To what extent do you think that staff should tolerate acting out behaviour in the community?

(c) Communalism Are the following features essential to a therapeutic community?

	YES	NO
1. Informal use of christian names between patients and staff.		
2. Sharing of amenities.		
3. Frank expression of thoughts and feelings.		
4. Communal staff-patient decision making.		

Section 8 Patient and Staff Selection in a Therapeutic Community

22. In your opinion would different types of disorders respond equally as well to treatment in a therapeutic milieu?

23. What methods of treatment do you consider would best suit patient disorders diagnosed as follows:-

Disorder	Treatment Method
Endogenous depression	
Psychopathy	
Schizophrenic - type	
Personality disorders	

25. (a) Should staff be specially selected for work in a therapeutic community?

(b) Does this work involve special skills or personality attributes?

39. What type of disorder do you think best responds to treatment in a therapeutic community milieu?

Section 9 Role and Task Satisfaction

26. Do you feel that you can fulfil your role as well in a therapeutic community as you might in a more conventional setting?

27. If you face any difficulties in your job that you think you would not face in a more conventional setting, what kinds of things would these be?

34. What kinds of strains do you encounter in therapeutic community work?

36. Would you say that democratic participation of staff in a therapeutic community serves to undermine their authority?

Section 10. Institutionalisation

28. Would you say that many of the older 'long-stay' patients in mental hospitals stand little chance of being rehabilitated into the wider community?

31. Do you think that 'longer-stay' and 'chronically' disturbed patients can benefit from treatment in a therapeutic community?

32. Do you think that involvement in a therapeutic community can help to overcome the effects of 'institutionalisation'?

APPENDIX TO CHAPTER 8

DATA RELATING TO SECTIONS 1 - 10

Section 1 General Information - (Q 1-7)

(a) Total number of interviews 133 79 Male 53 Female
69 British 48 Foreign

(b) All interviews carried out between March - August 1971.

(c) Composition of Staff interviewed see Figure 5, Chapter 8, P.209
including (i) average age of professional groups
(ii) average length of service and 'range' of service.

(d) Hospitals/Units visited

1. Fulborne Hospital, Cambridge
2. Claybury Hospital, Essex
3. Shenley Hospital, Hertfordshire
4. Henderson Hospital, Surrey
5. Dingleton Hospital, Roxburghshire, Scotland
6. Northgate Clinic, West Hendon General Hospital, Middlesex.

Section 2 Previous Experience (Q 8-9)

8. Have you previously worked in a psychiatric hospital/Unit?

9. How would you describe the type of treatment approach in use there?

Professional Groups	Q8 Previous Experience: % Having previous exper. of psychiatric Hospital/Unit	Q9 Description of Treatment Approach: Traditional/ Custodial %	Therapeutic Community Approach %	Eclectic Other %	
Consultants	100	35	12	62	Medical Personnel
Registrars	100	23	21	56	
Junior Doctors	50	50	-	50	
Administrative	91	18	18	64	Non-Medical Personnel
S/W's & O/TS	55	15	-	85	
Psychologists	100	33	-	-	
Charge Nurses	67	78	-	22	Nursing Personnel
Sisters	25	17	17	-	
Qual.Nurses	60	45	5	50	
Stud.Nurses	20	40	7	53	
Social Therapists & Assis. Nurses	30	7	15	78	
Percentage Totals	63	32	9	59	100

* In questions 8-16, figures are expressed as percentages of each group's total number of responses and the figures at the bottom of the tables are percentage totals.

Section 3 Evaluation of Work Setting

Q 10 Is the Unit in which you are presently working any (a) more progressive (b) less progressive, than that in which you were previously working, or is it (c) much the same? (d) No former employment/other.

Professional Groups	More Progressive %	Less Progressive %	Much the same %	No Former Employment/ Other %
Consultants	100	-	-	-
Registrars	89	-	-	11
Junior Doctors	50	25	-	25
Administrators	91	-	-	9
S/WS & O/T'S	65	5	20	10
Psychologists	100	-	-	-
Charge Nurses	94	-	-	6
Sisters	100	-	-	-
Qual. Nurses	70	-	30	-
Student Nurses	80	-	13	7
Social Therapists & Assist. Nurses	92	-	-	7
Percentage Totals	85	3	6	7

11. What methods of treatment are currently being used in this hospital?

Methods of Treatment Identified

Professional Groups	Therapeutic Community	Eclectic	Group Psycho-therapy	Individual Psycho-therapy	Physical Therapies	Others
Consultants	66	22	12	-	-	-
Registrars	66	12	12	-	-	12
Jun. Doctors	50	25	25	-	-	-
Administrators	80	20	-	-	-	-
S/W'S & O/T'S	47	26	21	-	-	6
Psychologists	67	-	33	-	-	-
Charge Nurses	83	11	-	6	-	-
Sisters	83	8	8	-	-	-
Qual. Nurses	75	20	-	-	5	-
Student Nurses	47	20	33	-	-	-
Social Therapists & Ass. Nurses	100	-	-	-	-	-
Percentage Totals	69	15	13	5	4	2

Section 4 Treatment Preferences

12. Do you have a preference for any particular mode of treatment or treatment orientation?

Treatment Preferences - %

Professional Groups	Groups Therapies	Therapeutic Community	Eclectic	Milieu Therapies	Psychodynamic Approaches	Individual Therapies	Physical Therapies	Other
Consultants	12	37	12	-	37	-	-	-
Registrars	22	33	33	-	12	-	-	-
Jun. Doctors	25	-	25	25	-	25	-	-
Administrative	-	36	36	18	-	-	-	-
S/W'S & O/T'S	42	21	32	-	5	-	-	-
Psychologists	33	33	-	-	33	-	-	-
Charge Nurses	28	28	37	5	-	-	-	-
Sisters	67	25	-	8	-	-	-	-
Qual. Nurses	10	30	50	-	-	-	10	-
Stud. Nurses	40	20	33	-	-	7	-	-
Social Therapists & Ass. Nurses	33	17	17	-	8	-	-	25
Percentage Totals	28	25	25	5	5	3	1	2

14. Would you equate the use of therapeutic community methods in mental hospitals with progress in psychiatric practice?

Professional Groups	YES %	NO %
Consultants	100	-
Registrars	100	-
Jun. Doctors	25	775
Administrators	100	-
S/W'S & O/T'S	84	16
Psychologists	100	-
Charge Nurses	94	6
Sisters	75	25
Qual. Nurses	90	10
Student Nurses	92	8
Social Therapists & Assist. Nurses	92	8
Percentage Totals	84	16

Section 5 Therapeutic Community : Criteria of Definition

15. What would you describe as the central features of therapeutic community treatments?

Features of Milieux/Treatment Orientation - %

Professional Groups	Democratic Process	Commun-alism	Crisis Resolution Methods	The 'total' Milieu	Permissive Atmosphere	Psycho-therapy	The Staff	Don't Know	Other
Consultants	25	25	12.5	25	12.5	-	-	-	-
Registrars	11	11	-	45	22	11	-	-	-
Jun. Doctors	25	25	25	-	-	25	-	-	-
Administrators	18	18	27	9	27	-	-	-	-
S/W'S & O/T'S	15	20	15	15	15	5	5	-	5
Psychologists	33	33	33	-	-	-	-	-	-
Charge Nurses	10	26	15	15	10	10	5	5	-
Sisters	36	18	9	27	9	-	-	-	-
Qual. Nurses	35	15	-	10	15	10	5	5	-
Student Nurses	13	24	-	13	24	6	6	6	-
Social Therapists & Assist. Nurses	13	15	23	8	15	7	-	-	-
Percentage Totals	23	20	15	15	13	7	2	1	0.5

16. On what scale do you think a community can best function?

As a: Scale and Size

Professional Groups	Total Hospital	Autonomous External Unit	Dependent Ward/Unit	Patient No's Range	
Consultant	-	50	50	30-60	
Registrars	-	72	28	40-50	
Jun. Doctors	28	72	-	20-100	
Administrators	45	36	18	20-400	
S/W'S & O/T'S	23	33	41	20-40	
Psychologists	-	50	50	40-50	
Charge Nurses	31	44	25	6-60	
Sisters	23	23	54	20-50	
Qual.Nurses	24	30	44	20-200	
Stud. Nurses	40	20	40	15-30	
Soc. Therapists & Ass. Nurses	25	25	50	30	
Percentage Totals	28	41	36	6-400	Median Patient Size = 23.5

17. Do you agree/disagree that the problem of assessing the contribution of therapeutic community methods to psychiatric practice has arisen because:-

Professional Groups	TC Methods and goals are poorly defined		Mental disorders cannot be treated by these methods		Medical/Nursing training inappropriate		Milieu therapy methods supplemented		Everyone's conception of what is therapeutic differs	
	A	D	A	D	A	D	A	D	A	D
Consultants	8	-	-	8	8	-	4	4	8	-
Registrars	8	1	-	9	8	2	5	4	8	1
Jun. Doctors	5	-	-	5	4	1	3	1	4	-
Administrators	8	2	-	12	9	1	6	5	10	-
S/W'S & O/T'S	14	6	-	18	17	1	14	5	17	2
Psychologists	1	1	-	4	4	-	1	2	3	-
Charge Nurses	15	3	-	18	15	3	13	6	14	5
Sisters	8	4	-	11	13	-	10	3	12	1
Qual. Nurses	13	6	1	18	17	2	10	8	16	2
Stud. Nurses	12	4	-	14	9	5	5	9	11	3
Social Therapists & Assist. Nurses	12	2	-	15	14	-	8	7	11	5
Numerical Totals	104	29	1	132	118	15	79	54	114	19
Percentage Totals	71	29	1	99	89	11	59	41	86	14*

* Note: Figures in the columns are numerical totals for each group only, whereas at the bottom of the table, numerical totals and percentage totals are shown.

18. Which (if any) of the features of your community do you think may be untherapeutic for the patients?

Features Selected

Professional Groups	Lack of definition of goals/ structure	Dissatis. is; an scope of activities	Problems of Patient dependency	Staff/ patient Problems etc.	Problems of responsibility etc.	Problems with Meetings	Problems with psycho-therapy	Dislike of physical treatments	Authority/ discipline problems
Consultants	4	-	-	1	-	-	-	-	-
Registrars	3	-	-	2	1	1	-	-	1
Jun. Doctors	-	-	-	-	1	-	1	-	1
Administrators	5	-	-	-	3	1	1	-	-
S/W'S & O/T'S	4	-	-	3	3	1	2	2	9
Psychologists	1	-	-	-	1	-	-	-	-
Charge Nurses	5	-	-	1	2	1	2	2	6
Sisters	-	-	-	1	3	1	1	1	2
Qual. Nurses	4	1	1	-	3	-	2	1	6
Stud. Nurses	-	-	-	2	-	-	1	-	2
Social Therap. & Ass. Nurses	5	-	-	1	-	1	3	-	3
Numerical Totals	31	1	1	11	17	6	13	6	29
Selection by Rank Order	1	8	8	5	3	6	4	6	2

Section 6 Effectiveness of Therapeutic Community Methods

19. In your estimation, can therapeutic community methods be any more successful in rehabilitating patients than other treatment approaches?

Professional Groups	Yes	No	Don't Know/ Other
Consultants	8	-	-
Registrars	7	-	2
Jun. Doctors	3	-	-
Administrators	6	3	2
S/W'S & O/T'S	15	3	1
Psychologists	2	-	1
Charge Nurses	13	3	1
Sisters	11	-	-
Qual. Nurses	17	6	1
Student Nurses	12	2	-
Social Therapists & Ass. Nurses	11	1	2
Numerical Totals	104	18	10
Percentage Totals	79	18	7

21. Is it realistic to say that one of the primary aims of a therapeutic community is to get an individual back into the wider community as soon as possible?

Professional Groups	Realistic	Unrealistic	
Consultants	3	3	
Registrars	6	2	
Jun. Doctors	2	2	
Administrators	7	4	
S/W'S & O/T'S	12	8	
Psychologists	2	1	
Charge Nurses	13	5	
Sisters	9	3	
Qual. Nurses	18	4	
Students	12	1	
Social Therapists & Ass. Nurses	10	4	
Numerical Totals	94	37	131 respondants
Percentage Totals	72	28	

33. How would you define 'effectiveness' in terms of therapeutic community success?

Criteria of Effectiveness

Professional Groups	Patient Oriented Criteria	Staff-oriented Criteria	Externally Oriented Criteria	Other/ Don't Know	Totals
Consultants	6	-	2	-	8
Registrars	4	1	3	-	8
Jun. Doctors	2	1	2	-	5
Administrators	1	1	6	-	8
S/W'S & O/T'S	7	6	5	1	19
Psychologists	2	1	1	-	4
Charge Nurses	6	4	8	-	18
Sisters	7	-	5	1	13
Qual. Nurses	5	6	8	-	19
Stud. Nurses	3	4	8	-	15
Social Therapists & Ass. Nurses	8	7	-	-	15
Numerical Totals	51	31	48	2	132
Percentage Totals	39	23	36	1	100

43. Do you see 'community therapy' as an answer to future problems of mental disorder?

Professional Groups	Yes	No	Partial Answer Only	Totals
Consultants	5	-	3	8
Registrars	7	1	1	9
Jun. Doctors	3	-	1	4
Administrators	9	-	2	11
S/W'S & O/T'S	10	7	2	19
Psychologists	3	-	-	3
Charge Nurses	11	4	3	18
Sisters	8	2	2	12
Qual. Nurses	13	3	3	19
Stud. Nurses	10	4	1	15
Social Therapists & Ass. Nurses	10	-	4	14
Numerical Totals	89	21	22	132
Percentage Totals	67	16	17	100

Section 7 Operative Treatment Processes

(a) Democratization: Do you think that all members of the community should share equally in therapeutic and administrative decision making.

(c) Communalism: Are the following features essential to a therapeutic community: (1) Informal use of christian names between patients and staff, (2) Sharing of amenities, (3) Frank expression of thoughts and feelings, (4) Communal staff/patient decision making.

	(a) Democratization		(c) Communalism							
			1		2		3		4	
Professional Groups	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Consultants	3	3	5	2	6	1	6	1	5	2
Registrars	6	3	7	2	7	1	7	1	8	1
Jun.Doctors	1	3	3	1	2	1	4	-	4	-
Administrators	8	3	10	1	9	2	11	-	11	-
S/W'S & O/T'S	10	10	18	1	19	-	14	4	16	3
Psychologists	1	2	2	-	2	1	2	-	2	1
Charge Nurses	12	6	21	1	16	3	18	1	15	4
Sisters	12	-	12	-	11	1	11	1	12	-
Qual.Nurses	13	8	21	-	21	-	17	4	17	4
Stud.Nurses	10	-	11	-	10	-	9	1	6	4
Soc.Therapists & Ass. Nurses	9	6	14	1	14	-	15	-	14	-
Numerical Totals	85	44	124	9	117	10	114	13	110	19
Percentage Totals	66	44	93	7	92	8	90	10	75	25

20b. Permissiveness: To what extent do you think staff should tolerate acting-out behaviour in the community?

Range of Replies

Professional Groups	No Limits	Until likely to damage the Community	Until likely to damage the patient	Until it becomes intolerable to staff	Ignore it completely	Controlled carefully	Not at all	Other
Consultants	-	4	1	-	-	1	1	-
Registrars	1	5	2	-	-	-	-	-
Jun. Doctors	-	2	2	-	-	-	1	-
Administrators	2	7	-	-	-	1	-	1
S/W'S & O/T'S	5	7	2	2	-	1	2	-
Psychologists	-	2	-	-	-	-	-	-
Charge Nurses	2	3	3	2	1	3	4	-
Sisters	2	7	2	-	-	-	1	-
Qual. Nurses	3	5	2	3	-	2	7	-
Student Nurses	4	4	-	3	-	1	2	1
Social Therapists & Asst. Nurses	-	8	2	2	1	1	-	1
Numerical Totals	19	54	17	12	2	10	18	3
Percentage Totals	14	41	13	9	1.5	8	14	2.2

Section 8. Patient and Staff Selection in a Therapeutic Community

22. In your opinion would different types of disorders respond equally as well to treatment in a therapeutic milieu?

Professional Groups	YES	NO	OTHER	TOTALS
Consultants	1	7	-	8
Registrars	5	4	-	9
Jun. Doctors	2	1	1	4
Administrators	7	3	-	10
S/W'S & O/T'S	2	16	-	18
Psychologists	-	3	-	3
Charge Nurses	5	12	1	18
Sisters	5	7	-	12
Qual. Nurses	12	8	-	20
Stud. Nurses	6	7	1	14
Social Therapists & Ass. Nurses	4	9	1	14
Numerical Totals	44	77	4	130
Percentage Totals	38	59	3	100

23. What mode of treatment would best suit the following disorders:-

Diagnostic Types

Professional Groups	Endogenous Depression							Psychopathy							Schizophrenia							Personality Disorders						
	1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
Consultants	1	-	-	2	2	1	-	-	1	1	5	-	-	1	3	-	-	5	-	-	1	-	-	1	3	1	-	2
Registrars	1	2	2	3	2	-	-	-	3	1	5	-	-	-	1	1	1	5	1	-	-	-	1	1	6	-	-	-
Jun. Doctors	1	-	-	1	3	-	-	-	1	1	2	1	-	-	1	-	1	3	-	-	-	-	1	1	3	-	-	-
Administrators	1	1	2	5	-	-	-	-	-	-	9	-	-	-	1	-	-	6	1	-	-	-	-	-	9	-	-	-
S/W'S & O/T'S	2	1	3	7	3	-	5	-	1	3	6	2	-	7	2	1	1	5	2	1	6	-	1	4	5	2	2	6
Psychologists	1	-	1	-	-	-	-	-	-	-	2	-	-	-	1	-	2	-	-	-	1	-	-	-	2	-	-	-
Charge Nurses	5	1	1	4	5	-	3	-	1	4	3	-	2	7	4	1	4	5	3	-	1	-	-	5	7	1	2	3
Sisters	2	-	1	5	2	1	1	-	-	3	3	1	3	4	3	-	2	3	4	-	1	-	-	2	6	1	2	2
Qual. Nurses	3	1	4	6	2	-	4	1	-	2	8	1	1	6	6	1	-	7	2	-	3	1	-	4	8	1	-	5
Stud. Nurses	4	1	5	1	4	-	1	3	2	2	1	2	1	4	9	-	1	2	3	-	1	3	3	4	2	-	1	4
Social Therapists & Ass. Nurses	1	2	6	3	1	1	-	1	-	2	6	1	-	2	-	-	1	4	3	-	4	-	1	3	7	1	-	1
Numerical Totals	22	9	25	37	24	3	14	5	9	19	50	8	7	31	31	4	13	45	19	1	18	4	7	25	58	7	7	22
Rank Scoring of each column	4	6	2	1	3	7	5	7	4	3	1	5	6	2	2	6	5	1	3	7	4	7	5	2	1	5	5	3

Range of answers to this question included following treatment approaches:

KEY: 1. Physical Therapies 2. Individual Psychotherapy 3. Group Therapies 4. Therapeutic Community/Milieu Therapy
5. Eclectic approach 6. Outpatient therapy 7. Don't know/Other

These numbers correspond with the column numbers on the table.

25a. Should staff be specially selected for work in a therapeutic community?

b. Does this work involve special skills or personality attributes?

Professional Groups	A. Special Selection		B. Skills/Personality Attributes			
	Yes	No	Both Skills and Personality Attributes	Special Skills	Personality Attributes	Don't Know/ Other
Consultants	6	2	2	1	3	2
Registrars	8	1	4	1	3	-
Jun. Doctors	3	1	1	-	3	-
Administrators	11	-	4	-	6	1
S/W'S & O/T'S	16	2	4	-	10	5
Psychologists	3	-	1	-	2	-
Charge Nurses	15	2	7	2	4	3
Sisters	11	1	6	-	4	2
Qual. Nurses	13	8	4	-	11	8
Stud. Nurses	6	6	4	-	2	5
Social Therapists & Ass. Nurses	16	2	7	-	9	2
Numerical Totals	108	25	44	4	57	28
Percentage Totals	81	19	33	3	43	21

39. What type do you think best responds to treatment in a therapeutic community milieu?

Range of replies

Professional Groups	Personality Disorders	Psychopathic Disorder	Psychoneurotic Disorders	Schizophrenic Conditions	Institutional Neurosis: Func. Geriatric Conditions	All Conditions	Don't Know Other	Totals
Consultants	5	-	1	1	-	1	-	8
Registrars	3	1	-	-	1	1	3	9
Jun. Doctors	1	-	-	-	-	1	2	4
Administrators	5	1	-	-	1	2	2	11
S/W'S & O/T'S	8	1	4	1	-	2	3	19
Psychologists	1	-	-	-	-	1	-	2
Charge Nurses	7	1	2	4	1	1	2	18
Sisters	7	-	3	-	-	1	1	12
Qual. Nurses	8	2	7	3	-	5	-	25
Stud. Nurses	-	1	6	1	-	1	1	10
Soc. Therapists & Ass. Nurses	7	2	2	1	-	2	-	14
Numerical Totals	52	9	25	11	3	18	14	132
Percentage Totals	39	7	19	8	2	14	11	100
Rank Order	1	6	2	5	7	3	4	

Section 9 Role and Task Satisfaction

26. Do you feel that you can fulfill your role as well in a therapeutic community as you might in a more conventional setting?

Professional Groups	No	Yes	Better	No Comparison	Other/ Don't know	
Consultants	-	3	4	-	-	
Registrars	1	5	3	-	-	
Jun. Doctors	-	2	2	-	-	
Administrators	2	7	2	-	-	
S/W'S & O/T'S	4	5	7	1	1	
Psychologists	-	-	3	-	-	
Charge Nurses	4	9	6	-	-	
Sisters	-	9	2	-	1	
Qual. Nurses	4	7	7	-	-	
StudentsNurses	2	14	1	-	-	
Soc. Therapists & Ass. Nurses	1	5	8	-	-	
Numerical Totals	18	66	46	1	2	133
Percentage Totals	13	50	34	0.7	1.5	100
		84				

27. If you face any difficulties in your job that you think you would not face in a more conventional setting, what kinds of things would these be?

Range of Responses

Professional Groups	Exposure Vulnerability Responsibility	Fears Suspicions Staff Pathology	Role Confusion Admin./practical problems Goal confusion	No problems Inapplicable No comparisons	Totals
Consultants	4	2	1	1	8
Registrars	5	1	3	-	9
Jun. Doctors	2	1	-	1	4
Administrators	3	-	2	6	11
S/W'S & O/T'S	10	-	6	2	18
Psychologists	-	-	1	2	3
Charge Nurses	10	2	6	1	19
Sisters	5	-	4	2	11
Qual. Nurses	14	1	2	4	21
Stud. Nurses	6	2	1	3	12
Soc. Therapists & Ass. Nurses	9	-	5	1	15
Numerical Totals	68	9	31	23	131
Percentage Totals	52	7	24	18	100

34. What kinds of strains do you encounter in therapeutic community work?

Range of Responses

Professional Groups	Emotional Strains	Role strains Authority Problems	Threats to Physical Welfare	Confusion over goals and aims	None	Other	Totals
Consultants	7	1	-	-	-	-	8
Registrars	6	3	-	-	-	-	9
Jun. Doctors	2	1	-	1	-	-	4
Administrators	4	2	-	4	1	-	12
S/W'S & O/T'S	10	4	-	2	-	2	18
Psychologists	2	1	-	-	-	-	3
Charge Nurses	9	3	1	4	1	-	18
Sisters	8	1	-	1	1	1	12
Qual. Nurses	7	10	-	-	3	-	20
Stud. Nurses	9	1	2	1	2	-	15
Soc. Therapists & Ass. Nurses	12	2	-	-	-	-	14
Numerical Totals	76	29	3	13	8	3	132
Percentage Totals	58	22	2	10	6	2	100

36. Would you say that democratic participation of staff in a therapeutic community serves to undermine their authority?

Professional Groups	Yes	No	Other	Totals
Consultants	4	2	3	9
Registrars	5	4	1	10
Jun. Doctors	1	2	-	3
Administrators	5	5	1	11
S/W'S & O/T'S	8	9	2	19
Psychologists	2	1	-	3
Charge Nurses	7	9	2	18
Sisters	4	8	1	13
Qual. Nurses	6	12	1	19
Stud. Nurses	3	11	-	14
Soc. Therapists & Ass. Nurses	8	5	1	14
Numerical Totals	53	68	12	133
Percentage Totals	40	51	9	100

Section 10 Institutionalisation

28. Would you say that many of the older 'longstay' patients in mental hospitals stand little chance of being rehabilitated into the wider community?

Professional Groups	Yes	No	Other
Consultants	4	-	1
Registrars	6	-	-
Jun. Doctors	3	-	1
Administrators	7	-	-
S/W'S & O/T'S	7	2	3
Psychologists	1	-	-
Charge Nurses	12	1	2
Sisters	7	1	1
Qual. Nurses	15	3	1
Stud. Nurses	11	4	-
Social. Therap. & Ass. Nurses	7	-	-
Numerical Totals	83	11	9
Percentage Totals	81	11	9

31. Do you think that 'longer-stay' and chronically disturbed patients can benefit from treatment in a therapeutic community?

Professional Groups	Yes	No	Don't Know/Other
Consultants	7	1	-
Registrars	7	1	1
Jun. Doctors	2	1	1
Administrators	7	2	1
S/W'S & O/T'S	14	3	2
Psychologists	1	-	1
Charge Nurses	12	6	-
Sisters	9	2	2
Qual. Nurses	10	11	1
Stud. Nurses	5	6	2
Soc. Therapists & Asst. Nurses	9	2	3
Numerical Totals	83	35	14
Percentage Totals	63	26	11

32. Do you think that involvement in a therapeutic community can help to overcome the effects of 'institutionalisation'?

Professional Groups	Yes	No	Other
Consultants	8	-	-
Registrars	8	1	-
Jun. Doctors	2	2	-
Administrators	11	-	-
S/W'S & O/T'S	15	2	1
Psychologists	2	1	-
Charge Nurses	16	1	2
Sisters	9	1	1
Qual. Nurses	16	4	-
Stud. Nurses	11	3	1
Soc. Therapists & Ass. Nurses	11	2	2
Numerical Totals	109	17	7
Percentage Totals	82	13	5

APPENDIX TO CHAPTER 13

APPENDIX TO CHAPTER 13

1. Table showing Patients' Attendances at Groups, Tuesday and Thursday Meetings as a Percentage of Total Possible Attendances, 1st April 1971 to 31st March, 1972

Spearman Rank Correlation Coefficient

R = Rank Order

Name	Groups		Thursday Meeting		Tuesday Meeting		(1)		(2)		(3)	
	%	R	%	R	%	R	d	d^2	d	d^2	d	d^2
T	93	5.5	88	6	75	4	1.5	2.25	0.5	0.25	2	4
M	77	12	69	9	19	16	4	16	3	9	7	49
R	92	7	63	12	76	3	4	16	5	25	9	81
K	89	8	65	11	62	8	0	0	4	16	3	9
L	93	5.5	73	8	54	9	3.5	12.25	2.5	6.25	1	1
S	74	14	93	3	64	7	7	49	11	121	4	16
C	83	11	90	4	66	6	5	25	7	49	2	4
E	97	3	82	7	43	11	8	64	4	16	4	16
J	88	9	25	17	17	17	8	64	8	64	0	0
J	86	10	28	15	29	12.5	2.5	6.25	5	25	2.5	6.25
M	76	13	67	10	53	10	3	9	3	9	0	0
B	95	4	96	2	85	2	2	4	2	4	0	0
A	98	2	100	1	100	1	1	1	1	1	0	0
L	71	15	26	16	22	14	1	1	1	1	2	4
J	60	16	42	14	29	12.5	3.5	12.25	2	4	1.5	2.25
P	100	1	89	5	67	5	4	16	4	16	0	0
S	58	17	50	13	20	15	2	14	4	16	2	4
								312		382.5		196.5

Formula: $1 - \frac{6(\Sigma d^2)}{n(n^2-1)}$

1. Comparison of Groups with Tuesday Meeting attendances

$$1 - \frac{1872}{4896} = 0.62 \longleftarrow$$

2. Comparison of Groups with Thursday Meeting Attendances

$$1 - \frac{2295}{4896} = 0.95 \longleftarrow$$

3. Comparison of Tuesday with Thursday Meeting Attendances

$$1 - \frac{1179}{4896} = 0.76 \longleftarrow$$

When N=17, at the .01 level of significance rs = .601, therefore, in each case there is a significant correlation since the null hypothesis which suggests that two sets of data are not associated in a given population, is rejected.[1]

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[1] Siegal S. Nonparametric Statistics for the Behavioural Sciences McGraw-Hill 1956 pp.210-211.

2. Chi Square Table showing Comparative Attendance Figures in Percentages for Groups, Thursday and Tuesday Meetings, 1st April, 1971 to 31st March, 1972

	Groups		Thursday		Tuesday		Totals
	O	E	O	E	O	E	
Female Attendances %	85.4	92.0	68.4	65.7	44.0	-	197.7
Male Attendances %	83.0	88.4	66.5	69.2	58.8	-	208.3
	168.4		134.9		102.8		406.0

Observed	Expected	O - E	$(O - E)^2$	$\frac{O - E^2}{E}$
85.4	92.0	-6.6	44.2	0.480
83.0	88.4	-5.4	29.3	0.331
68.4	65.7	+2.7	7.2	0.109
66.5	69.2	-2.6	7.0	0.101
44.0	50.0	-6.0	36.6	0.731
58.8	52.7	+6.0	36.6	0.694
				2.447 χ^2

With two degrees of freedom, the value of χ^2 at the 0.5 level of significance is 5.99. The calculated value of χ^2 - 2.45 - does not exceed this value and therefore suggests that any differences between male and female attendances at the three types of meeting, are not statistically significant.

3. RATING SCALES OF PATIENTS' BEHAVIOUR

T. M. CAINE

Patient's name _____

RATING SCALES OF PATIENTS' BEHAVIOUR

1. Attitude to the group as a whole (shown by infrequent attendance, lack of involvement, rejection of treatment method etc.)

destructive — constructive

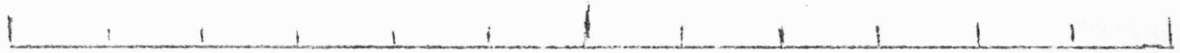
2. Attitude to other individual members of the group

undifferentiated hostility to all — non-compulsive reality based, adjustive etc. — undifferentiated ingratiation to all

3. General behaviour

Consistent — inconsistent

4. Suspiciousness

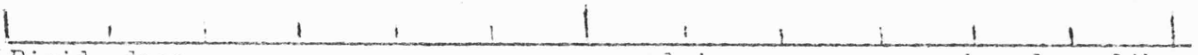


suspicious of others' motives — non-compulsive, reali y based, adjustive, etc. — naive trust in others

5. Egocentricity

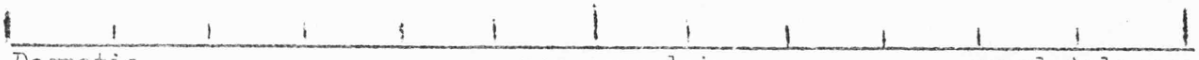
Egocentric — non-compulsive, reality based, adjustive, etc. — over concerned for others

6. Rigidity



Rigid, does not change or broaden with experience. — non-compulsive, reality based, adjustive, etc. — chameleon-like changes completely inconsistent

7. Dogmatism



Dogmatic — non-compulsive, reality based, adjustive, etc. — completely confused, agrees to everything

8. Dependence

Childishly dependant — non-compulsive, reality based, adjustive etc. — stubbornly independent

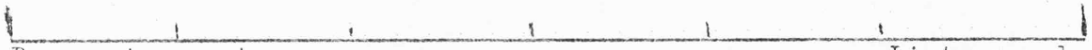
9. Willingness to reveal self

Secretive, reticent — non-compulsive, reality based, adjustive etc. — exhibitionist display

10. Verbal participation

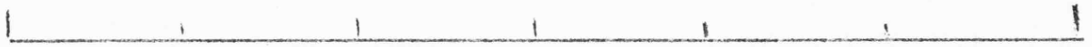
Talkative — silent

11. Taking in what is said



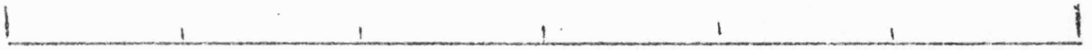
Does not seem to listen, nothing sinks in — Listens and uses what is said to him

12. Insight at an intellectual level



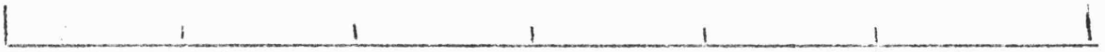
able to make interpretations, understands dynamics — does not try to interpret, does not understand dynamics

13. Insight at an emotional level



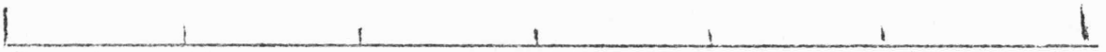
able to understand and accept own true feelings and needs — self-deceptive, unable to accept self

14. Empathy



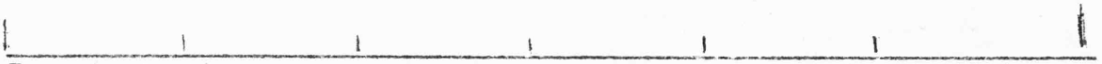
cannot see and accept others' points of view — feels with others and is able to see things their way

15. Ability to accept criticism



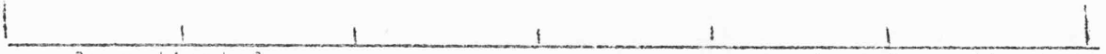
Cannot accept criticism — accepts criticism, and able to modify behaviour

16. Ability to offer criticism



Is not afraid to criticize others — is afraid to criticize others

17. Motivation to change



poorly motivated, large element of "gain" in illness, easily put off — strongly motivated, persists with treatment, works hard.

4. Table showing Staff and Therapists Ratings of Patients' Behaviour in Groups in Response to Caine's 'Rating of Patients Behaviour'

Spearman Rank Correlation Coefficient

R = Rank Order

Name	Staff	R	Therapists	R	d	d^2
R	70.3	1	64	2	1	1
M	68.0	2	55	4	2	4
S	59.3	8	68	1	-7	49
J	63.0	3	56	3	0	0
B	62.3	4	43	12	8	64
L	58.7	9	53	5.5	-3.5	12.25
L	60.7	6	45	10.5	4.5	20.25
A	59.7	7	53	5.5	-1.5	2.25
C	61.3	5	45	10.5	5.5	30.25
O	58.0	10	48	9	-1	1
P	48.7	14	52	7.5	-6.5	42.25
E	54.3	11	41	13	2	4
T	42.0	17	52	7.5	-9.5	90.25
S	51.0	12	24	17	5	25
K	46.0	15	38	14	-1	1
M	49.7	13	25	16	3	9
J	43.3	16	27	15	-1	1
						356.5

Formula: $1 - \frac{6(\Sigma d^2)}{n(n^2-1)}$

Comparison of Staff and Therapists Scores

$$1 - \frac{2139}{4896} = 1 - 0.437 = 0.563 \longleftarrow r_s$$

When N=17, the nearest value for rho at the .05 level of significance is 0.425 (N=16) or 0.399 (N=18). Since the calculated value of 0.563 exceeds both of these values the null hypothesis which suggests that the two sets of data are not associated, is rejected. A correlation is, therefore, said to exist between the opinions of staff and therapists concerning patients behaviour in group psychotherapy.

5. Table showing the comparative Ratings of Patients Behaviour in Groups provided by Woodside Villa's Charge Nurses, in Response to Caine's 'Rating Scales of Patients' Behaviour'.

Spearman Rank Correlation Coefficient

R. = Rank Order

Name	Charge Nurse (1)	R	Charge Nurse (2)	R	d	d^2
R	65	4	77	1	-3	9
M	70	3	70	6	3	9
J	72	1	58	11.5	10.5	110.3
B	62	5	65	9	4	16
C	49	10.5	76	3	-7.5	56.2
L	58	6.5	76	3	-3.5	12.2
A	71	2	54	15	13	169
S	51	9	69	7	2	4
L	58	6.5	68	8	1.5	2.2
J	47	12	76	3	-9	81
E	33	16	71	5	-11	121
S	49	10.5	56	13.5	3	9
M	45	13.5	89	10	-3.5	12.2
P	41	15	56	13.5	-1.5	2.2
K	45	13.5	58	11.5	-2	4
J	52	8	47	17	9	81
T	27	17	50	16	-1	1
						699.3

Formula $1 - \frac{6(\Sigma d^2)}{n(n^2-1)}$

Comparison of Charge Nurses Ratings of Patients Behaviour

$$1 - \frac{4195.8}{4896} = 1 - 0.857 = 0.143 \longleftarrow r^s$$

When N=17 at the .05 level of significance, the calculated value of rho must achieve between 0.425 and 0.399 for the variation between the data samples to be insignificant i.e. due to random error. Since the above figure of 0.143 lies well below either of these two values, it is concluded that the differences in the scoring of patients behaviour in groups by the two charge nurses are significant.

6. Table showing the comparative Ratings of Patients' Behaviour in Groups provided by Woodside Villa's Charge Nurse (1) and (2) and (one available) Nursing Sister in Response to Caine's 'Rating Scales of Patients' Behaviour'

Spearman Rank Correlation Coefficient

Name of Patient	Charge Nurse (1)	R	Charge Nurse (2)	R	Sister	R	(1) d	(1) d^2	(2) d	(2) d^2
R	65	4	77	1	69	1	-3	9	0	0
M	70	3	70	6	64	2	-1	1	-4	16
JJ	72	1	58	11.5	59	6	5	25	-5.5	30.2
B	62	5	65	9	60	3.5	-1.5	2.2	-5.5	30.2
C	49	10.5	76	3	59	6	-4.5	20.2	3	9
L	58	6.5	76	3	48	13.5	7	49	10	100
A	71	2	54	15	54	9	7	49	-6	36
S	51	9	69	7	58	8	-1	1	1	1
L	58	6.5	68	8	60	3.5	-3	9	-4.5	20.2
J	47	12	76	3	51	10	-2	4	7	49
E	33	16	71	5	59	6	-10	100	1	1
S	49	10.5	56	13.5	48	13.5	3	9	0	0
M	45	13.5	59	10	44	15	1.5	2.2	5	25
P	41	15	56	13.5	49	11.5	-3.5	12.2	2	4
K	45	13.5	58	11.5	35	16	2.5	6.2	4.5	20.2
J	52	8	47	17	31	17	9	81	0	0
T	27	17	50	16	49	11.5	-5.5	30.2	-4.5	20.2
								410.2		362.0

Formula $1 - \frac{6(\Sigma d^2)}{n(n^2-1)}$

1. Comparison of Charge Nurse (1) and Sister's Ratings of Patients' Behaviour in Groups

$$1 - \frac{2461.2}{4896} = 1 - 0.503 = 0.497 \longleftarrow r^s$$

2. Comparison of Charge Nurse (2) and Sister's Ratings of Patients Behaviour in Groups

$$1 - \frac{2172}{4896} = 1 - 0.444 = 0.556 \longleftarrow r^s$$

When N=17 the nearest value for rho at the .05 level of significance is 0.425 (N=16) or).399 (N=18). Since both of the calculated values above exceed these values, the null hypothesis which suggests that the data samples are not associated, is rejected, and it is concluded that the opinions of charge nurses and sister concerning patients behaviour in groups are basically complementary.

7. Table showing the Comparative Ratings of Patient Behaviour in Groups, Diagnostic Classification, provided by Staff and Therapists at Woodside Villa in Response to Caine's 'Rating Scales of Patient Behaviour'.

	Name of Patient	Charge Nurse (1)	Charge Nurse (2)	Sister	Therapists	Average Scores
Non-Psychotic	J	72	58	51	56	61.2
	E	33	71	59	41	48.5
	P	41	56	49	52	49.5
	J	47	76	51	48	55.5
	A	71	54	54	53	58.0
	R	65	77	69	64	68.7
	M	70	70	64	55	61.7
	K	45	58	35	38	44.0
	C	49	76	59	45	57.2
	L	58	68	60	53	59.7
Average		55.1	66.4	55.9	50.5	56.4
Psychotic	J	52	47	31	27	39.2
	S	51	69	58	68	61.5
	B	62	65	60	43	60.0
	L	58	76	48	45	59.2
	M	45	59	44	25	43.2
	S	49	56	48	24	44.2
	T	27	50	49	52	44.5
Average		49.1	60.3	48.3	40.6	50.3

8. Chi Square Table showing the Comparative Ratings of Patients' Behaviour in Groups by Diagnostic Classification, taken from Table 7

O = Observed E = Expected

	Psychotic		Non-Psychotic		Total
	O	E	O	E	
Charge Nurse (1)	49.1	48.5	55.1	55.7	104.2
Charge Nurse (2)	60.3	59.0	66.4	67.7	126.7
Sister	48.3	48.5	55.9	55.7	104.2
Therapists	40.6	42.0	50.5	48.1	90.1
Total	198.3	198.3	227.9	227.3	426.2

Formula: $\chi^2 = \frac{\xi (O-E)^2}{E}$

Table of Calculations

	O	E	O - E	$(O - E)^2$	$\frac{(O - E)^2}{E}$
Psychotic	49.1	48.5	+0.61	0.37	0.0076
	60.3	59.0	+1.34	1.80	0.0305
	48.3	48.5	-0.19	0.04	0.0008
	40.6	42.0	-1.28	1.64	0.0391
Non-Psychotic	55.1	55.7	-0.61	0.37	0.0066
	66.4	67.7	-1.35	1.82	0.0026
	55.9	55.7	+0.19	0.04	0.0007
	50.5	48.1	+2.40	5.80	0.1208
					0.2087 χ^2

The value of χ^2 is calculated to be 0.21

9. Table Showing Comparative Scores for Behavioural Components on Caine's 'Rating Scales of Patients' Behaviour', by Diagnostic Group.

Spearman Rank Correlation Coefficient

R = Rank Order

Behavioural Components	Psychotic	R	Non-Psychotic	R	d	d^2
Attitude to Group Members	4.43	1	4.13	3	2	4
Rigidity	4.33	2	4.17	2	0	0
General Behaviour	2.29	15.5	3.03	12.5	3	9
Dogmatism	3.90	3	3.93	5	2	4
Ability to Offer Criticism	3.33	4	3.50	9	5	25
Suspiciousness	3.19	8	4.50	1	7	49
Attitude to the Group	2.33	14	3.03	12.5	1.5	2.25
Taking in What is said	2.95	10	3.20	11	1	1
Egocentricity	3.29	5.5	3.73	6	0.5	0.25
Empathy	2.86	12	3.00	14	2	4
Willingness to reveal self	3.24	7	3.67	7	0	0
Dependence	3.29	5.5	3.47	10	4.5	20.25
Intellectual Insight	3.00	9	3.67	8	1	1
Verbal Participation	2.90	11	4.03	4	7	49
Motivation to Argue	2.29	15.5	2.70	16	0.5	0.25
Ability to Accept Criticism	2.62	13	2.90	15	2	4
Emotional Insight	1.95	7	2.40	17	0	0
						173.0

Formula: $1 - \frac{6(\Sigma d^2)}{n(n^2-1)}$

Comparison of Scores by Diagnostic Group

$$1 - \frac{1038}{4896} = 1 - 0.2119 = 0.788 \longleftarrow$$

The calculated value of rho exceeds 0.425 (N=16) at the .05 level of significance thus rejecting the null hypothesis which suggests that the data samples are <u>not</u> associated. It is, therefore, concluded that scores for the two diagnostic groups are <u>not</u> significantly different which perhaps suggests that Woodside's psychotherapeutic policy is therapeutically viable for patients of all diagnosis.

With three degrees of freedom (n= (2-1)(4-1) = 3) the critical values of ^{2} are 11.34 at the .01 level of significance, and 7.82 at the .05 level of significance. The calculated value of ^{2}, of 0.21, lies well below either of these values which would support the null hypothesis which states that differences in the scoring of psychotic and non-psychotic patients is due only to <u>random</u> variations and not to any significant differences in the opinions of staff and therapists concerning the adjustment of patients to group psychotherapy.

10. TREATMENT EXPECTANCIES QUESTIONNAIRE (T.E.Q.)

T. M. CAINE

For copy of questionnaire see following page.

The following are statements about the way many people feel about treatment. Please show how far you agree with these statements by circling the answers as follows:

T means you feel the statement is true

PT means you feel the statement is possibly true

PF means you feel the statement is possibly false

F means you feel the statement is false

Please answer every item

1. Treatment does not solve your problems but makes you able to cope with them. T PT PF F
2. Just talking will never help me overcome my basic fears. T PT PF F
3. Nobody will cure you, you've got to live with your problems. T PT PF F
4. I don't understand how people can have difficulties in getting on with each other. T PT PF F
5. I don't think talking over emotional problems serves any useful purpose. T PT PF F
6. Everybody's problems are different so it wouldn't help me to discuss mine with other patients. T PT PF F
7. Physical treatment (like tablets etc.,) is the best form of treatment for people with psychiatric illness. T PT PF F
8. I think that what I need is training in how to overcome my symptoms. T PT PF F
9. Only a specialist in mental treatments will be able to help me get better. T PT PF F
10. I have never felt any pressing need to talk about my emotional problems. T PT PF F
11. I can't see how other patients in treatment can help to cure anybody else except by chance or accident. T PT PF F

12. I have to learn to stop always thinking about myself when in the company of others. T PT PF F

13. There would be much less mental illness if people exerted more control over themselves. T PT PF F

14. I am the only person who can do anything about my problems. T PT PF F

15. The mere fact of understanding my illness will make me better. T PT PF F

16. What I need is for the doctor or therapist to tell me what I am doing wrong and what I should do about it. T PT PF F

17. I definitely feel that there is somebody who can cure me. T PT PF F

18. Learning to relax in difficult situations is an important part of treatment. T PT PF F

19. I only expect my symptoms to change after treatment and not myself as a person. T PT PF F

20. The personality of the therapist or doctor does not matter in treatment since it is his specialised knowledge that really counts. T PT PF F

21. Treatment is really being <u>taught</u> how to deal with difficult situations. T PT PF F

22. The doctor or therapist should always give direct advice to his patients. T PT PF F

23. Thinking about yourself too much can make you ill T PT PF F

24. I have come for treatment partly because I have difficulties in understanding what life is all about. T PT PF F

25. It is an important part of treatment for patients to believe that the doctors are all powerful. T PT PF F

26. Being myself and disclosing my weaknesses is an important part of treatment. T PT PF F.

27. A patient should not be expected to discuss really personal problems with the other patients. T PT PF F

28. It is important for the doctor not to show his real feelings to the patient. T PT PF F

11. DIRECTIONS OF INTERESTS QUESTIONNAIRE (D.I.Q.)

T. M. CAINE

(pp 342-344)

For copy of questionnaire see following page.

INSTRUCTIONS

Starting on the next page you will find a list of questions. These are arranged in pairs across the page. Please choose one or the other item in each pair as being TRUE or MORE TRUE than the other member of the pair.

An example is given below. Read the two statements and decide which is more true, on the whole, as far as you are concerned. Then put a tick in the space provided alongside the one you choose.

With some of the pairs of items you may feel that both statements are partly true, or that neither or them is really true. In this case try to choose the one that you feel is more true on the whole, but if you really cannot make up your mind, leave that question blank.

There are no right or wrong answers. It is simply a question of what you yourself prefer. There is no need to spend a lot of time making up your mind: there is no time limit, but quick decisions are usually the best.

Try to make a choice between each pair of items even it it is difficult to decide. Remember, choose the statement that comes nearer to your own views or feelings, and only leave a question blank if you really cannot make up your mind.

EXAMPLE

	Put a tick here or here	
I would prefer to live in the town	____ ____	I would prefer to live in the country

	Choose Here	
	1	
I prefer to see a film with a definite plot	____ ____	I prefer to see a film which leaves a lot to my imagination
	2	
I think of myself as realistic	____ ____	I think of myself as idealistic
	3	
I tend to get irritated by people who are always arguing about theories	____ ____	I tend to get irritated by people who are only interested in practical problems
	4	
In visiting places I am more interested in details than in 'atmosphere'	____ ____	In visiting places I am more interested in 'atmosphere' than in details
	5	
I would prefer to attend evening classes about the ideas underlying the various religions	____ ____	I would prefer to attend evening classes about the chemistry of the human body
	6	
I get on best with realistic people	____ ____	I get on best with imaginative people
	7	
I prefer conversations about the meaning of life	____ ____	I prefer conversations about practical, everyday things or problems
	8	
I would like to be known as a person of vision	____ ____	I would like to be known as a person of common sense
	9	
If I were a teacher I would prefer to teach engineering or domestic science	____ ____	If I were a teacher I would prefer to teach philosophy
	10	
I like a holiday without any definite plan of action	____ ____	I like a well planned holiday with pleanty of alternative activities

11

I prefer the conventional ways of doing things ____ ____ I prefer to invent my own ways of doing things

12

I usually prefer people who don't worry much about 'fitting in' ____ ____ I usually prefer people who take care to 'fit in'

13

I prefer to spend a free evening with a book about a person's emotional struggles with himself ____ ____ I prefer to spend a free evening with a book about the rise to power of a successful millionnaire

14

I would prefer to be known as a person who gets things done ____ ____ I would prefer to be known as a person who has original ideas

15

These questions have been easy to answer ____ ____ These questions have been difficult to answer

Please use this space for any comments you may wish to make about the questionnaire.

12. Table showing Comparative Scores on Caine's Direction of Interests Questionnaire by Diagnostic Group

Mann-Whitney 'U' Test

R = Rank

Non-Psychotic n^2			Psychotic n^1		
Name	Score	Rank	Name	Score	Rank
A	11	3	H	3	1
L	12	5	T	9	2
H	12	55	L	12	5
J	13	7	B	14	8
E	16	10.5	S	18	13.5
R	16	10.5	J	21	16
K	16	10.5	M	23	18
J	16	10.5	S	24	19
P	18	13.5			
M	20	15			
A	22	17			
D	26	20			

P Scores	3	9	12	14	18	21	23	24					n^1
NP Scores	11	12	12	13	16	16	16	16	18	20	22	26	n^2

Formula: $U = n^1n^2 + \frac{n^2(n^2+1)}{2} - R^2$

$U = (8)(12) + \frac{12\ (12+1)}{2} - 127.5$

$= 174 - 127.5 \qquad = 46.5 \longleftarrow U$

The null hypothesis which states that there are no significant differences between the two sets of scores is accepted, since at the .05 level of significance (for a sample size of between 9-20 only) the value of U would have to be equal to, or less than 26 for the null hypothesis to be rejected. This finding would suggest that diagnostic differences had little influence on patients' general suitability to psychotherapeutic treatment methods as assessed by the criteria of 'inner' and 'outer' directedness.

13. Table showing Comparative Scores on Caine's Treatment Expectancies (TEQ), by diagnostic group

Mann-Whitney 'U' Test

R = Rank

Non-Psychotic		n^2	Psychotic		n^1
Name	Score	Rank	Name	Score	Rank
A	35	13	T	32	9.5
L	41	18	L	38	16
H	23	3	B	32	9.5
J	29	7	S	41	18
E	18	1	J	33	11
R	35	13	M	28	5.5
K	28	5.5	S	35	13
J	24	4			
P	31	8			
M	22	2			
A	41	18			
N = 11		92.5 R^2	N = 7		83.5 R^2

Formula: $U = n^1n^2 + \frac{n^1(n^1+1)}{2} - R^2$

$U = (7)(11) + \frac{7(7+1)}{2} - 83.5$

$= 105 - 83.5 \qquad = 21.5 \longleftarrow U$

The null hypothesis which states that there are no significant differences between the two sets of scores is accepted, since at the .05 level of significance (for a sample size of between 9-20 only) the value of U would have to be equal to, or less than 19 for the null hypothesis to be rejected.

This finding suggests that diagnostic differences had little influence on patients' suitability to psychotherapeutic treatment methods as assessed by the criteria of 'expectations' concerning nature and aims of treatment as described in the TEQ.

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